

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

APPLICATION FOR DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

(Pursuant to 7 CFR 280)

In accordance with Federal law and USDA policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs or disability.

DO NOT WRITE IN SHADED AREAS

APPLICATION DATE:	INTERVIEW DATE	CENTER/OFFICE	UNIT	WORKER	CASE TYPE	CASE NUMBER	REGISTRY NUMBER	VERSION	LANG E OR S	LANG READ (NYC) XXXXXXXXXXXX
DISASTER AUTHORIZATION PERIOD: FROM: TO:		PAYMENT PERIOD FROM: TO:		HH SIZE		PAYMENT AMOUNT \$			1ST CARD NUMBER XXXXXXXXXXXXXXXXXXXXXXXXXXXX	

INSTRUCTIONS: Complete this application honestly and to the best of your knowledge. If your household knows but intentionally refuses on purpose to give any required information, it will not be eligible to receive DSNAP benefits. When you are interviewed, you must show identification. You must show proof that your household lived in the disaster area at the time of the disaster. You may have to verify any questionable expenses. You can authorize someone outside your household to apply for emergency aid and to get or use DSNAP benefits on your behalf.

Name: _____ Telephone Number: _____ Other phone where you can be reached: _____

Residence Address: _____ Apt. # _____ City _____, NY Zip Code: _____

Current Residence Address (if different): _____ Apt. # _____ City _____, NY Zip Code: _____

Mailing Address (if different): _____ Apt # _____ City _____, NY Zip Code: _____

PART A – HOUSEHOLD SITUATION

	YES	NO
1. Are you a current SNAP Participant? If Yes, STATE: _____ COUNTY: _____		
2. Was your household living in the disaster area at the time of the disaster? If yes, please answer the following questions:		
Did the disaster damage or destroy your home or self-employment property?		
Does your household have any additional un-reimbursed expenses as a result of the disaster?		
While the effects of the disaster are being cleaned up, will your household be buying food?		
Did the disaster delay, reduce or stop your household's income?		
Does your household have any cash or money in checking or savings accounts which you cannot get to because the accounts are not accessible due to the disaster?		
3. Are you or anyone in your household employed by New York State, NYC HRA or a local social services district? If Yes, where? _____		

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List the members of your household, including yourself, who were affected by the disaster who are living and eating with you. **IF YOU ARE TEMPORARILY STAYING WITH ANOTHER HOUSEHOLD BECAUSE OF THE DISASTER, DO NOT LIST MEMBERS OF THAT HOUSEHOLD IN PART B.** List each household member's Social Security Number (SSN), Date of Birth, and source and amount of take-home (net) pay. List any other income your household members have received or expect to receive while the DSNAP is operating. SSNs are not required to qualify for D-SNAP but can be used to identify your household members and to make sure they are eligible for DSNAP. They will also be used for computer matching, program reviews or audits.

PART B – HOUSEHOLD MEMBERS AND INCOME DURING THE DISASTER PERIOD

	First Name	MI	Last Name	Social Security Number (SSN) of household member (If none, write "None")	Date of Birth	Marital Status	Sex (M or F)	Hispanic or Latino?		Race*	Relationship to you	Income Source/Type	If wages, Name of Employer**	Freq. of Income	Net Income Amount
								Yes	No						
1											SELF				\$
2															\$
3															\$
4															\$
5															\$
6															\$
7															\$
8															\$
TOTAL HOUSEHOLD INCOME															\$

*Race/Ethnic Codes: **I** - Native American or Alaskan Native, **A** - Asian, **B** - Black or African American, **P** - Native Hawaiian or Pacific Islander, **W** - White

The provision of this information is voluntary, but if not completed, the interviewer may have to record by observation. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for this information is to ensure that program benefits are distributed without regard to race, color or national origin.

** For Each Employer listed above please provide their Name, Address and phone number.

Employer _____ Address: _____ Phone Number: _____
 Employer _____ Address: _____ Phone Number: _____
 Employer _____ Address: _____ Phone Number: _____

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In **Part C**, list all cash your household has access to during this disaster period. In **Part D**, list the disaster-caused expenses that your household paid or expects to pay during this disaster period, _____ to _____.

DO NOT INCLUDE EXPENSES THAT WERE PAID OR WILL BE PAID BY SOMEONE OUTSIDE YOUR HOUSEHOLD.

PART C – RESOURCES (as of the beginning of the disaster period)		AMOUNT
Cash on Hand		\$
Accessible Checking Accounts – Name of Bank _____		\$
Accessible Savings Accounts – Name of Bank _____		\$
TOTAL ACCESSIBLE CASH RESOURCES		\$
PART D – DISASTER EXPENSES (During the disaster period)		AMOUNT
Food destroyed as a result of the disaster		\$
Dependent care due to disaster		\$
Funeral/medical expenses due to disaster		\$
Moving and storage costs due to disaster		\$
Temporary Shelter expenses		\$
Cost to protect property during disaster		\$
Cost to repair or replace items for home or self-employment property		\$
Other disaster-related expenses		\$
TOTAL DISASTER EXPENSES		\$

PART E – PENALTY WARNING

If your household gets DSNAP it must follow the rules listed below. We may choose your household for a Federal or State review sometime after you receive your DSNAP benefits to make sure you were eligible for disaster aid. **DO NOT** give false information or hide information to get DSNAP or to continue to get SNAP. **DO NOT** give or sell DSNAP benefits or authorization documents to anyone not authorized to use them. **DO NOT** use DSNAP benefits to buy unauthorized items such as alcohol or tobacco. **DO NOT** use another household's DSNAP benefits for your household.

PART F – CERTIFICATION AND SIGNATURE

I understand the questions on this application and the penalties for hiding or giving false information. My household is in need of immediate food assistance as a result of the disaster, I certify, under penalty of perjury, that the information I have given is correct and complete to the best of my knowledge. I also authorize the release of any information necessary to determine the correctness of my certification. I understand that if I disagree with any action taken on my case, I have the right to request a fair hearing verbally (in person or by phone) or in writing.

APPLICANT, AUTHORIZED REPRESENTATIVE, OR WITNESS (if signed with an x):	Date Signed:
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PART G – ELIGIBILITY COMPUTATION (To be completed by a SNAP workers)

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DGIL (<\$100 in Disaster Expenses)	Amount	DGIL with DSED (>\$100 in Disaster Expenses)	Amount
1. Total anticipated income (From Part B)	\$	1. Total anticipated income	\$
2. Total accessible case resources (From Part C)	\$	2. Total accessible cash resources	\$
3. Add #1 and #2	\$	3. Add #1 and #2	\$
4. Total disaster expenses	\$	4. Maximum Gross Income Limit (amount from Disaster Table A)	\$
5. Total available funds (Subtract #4 from #3)	\$	5. ELIGIBLE (#3 is equal to or less than #4) Max Monthly Benefit Amount for HH of _____	\$
6. Maximum Gross Income Limit (Amount from Disaster Table B)	\$	6. INELIGIBLE (#3 is greater than #4)	\$
7. ELIGIBLE (#5 is equal to or less than #6) Max Monthly Benefit Amount for HH of _____	\$		
8. INELIGIBLE (#5 is greater than #6)	\$		

The US Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complain of discrimination, complete the USDA Program Discrimination complaint Form, found on-line at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at US Department of Agriculture, Direct, Office of Adjudication, 1400 Independence Avenue, SW Washington, DC 20250-9410, by fax (202) 690-7442 or e-mail at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the New York State Office of Temporary and Disability Assistance at (800) 342-3009 or contact your local social services district.

This information can also be found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm

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ATTESTATION OF DISABILITY

I, _____, did not apply for a Disaster Supplemental Nutrition Assistance Program (DSNAP) benefit in New York City in December 2012 because of a disability.

On October 27, 2012, I lived at:

Address: _____

City: _____ State: _____ Zip: _____

The address listed above is located within one of the following ZIP codes: 10002, 10306, 11224, 11235, 11231, 11691, 11692, 11693, 11694, 11697, 11229 (South of Allen Avenue in Coney Island), or 10305 (South of Seaview Avenue on Staten Island).

I state under penalty of perjury that the above is true and correct.

Print Name: _____
First Name M.I. Last Name

Signature: _____ Date: _____

APPLICATION SUPPLEMENT FOR DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM FOR PERSONS WITH DISABILITIES (D-SNAP PD)

Applicant's Name: _____ **Date:** _____

We require this information only to facilitate the processing of your case. Immigration status does not affect Disaster Supplemental Nutrition Assistance Program for Persons with Disabilities (D-SNAP PD) eligibility.

EMPLOYMENT INFORMATION						
If you included employment information in Part B - Household Members and Income During the Disaster Period of the Application for Disaster Supplemental Nutrition Assistance Program (SNAP) (LDSS-4988), we need the following information for each household member listed with income between October 27, 2012 and November 25, 2012:						
	First Name	MI	Last Name	Employer	Monthly hours worked:	Day of the week paid:
1						
2						
3						
4						
5						
6						
7						
8						

CITIZENSHIP INFORMATION
Are you a US Citizen ? <input type="checkbox"/> Yes <input type="checkbox"/> No

LANGUAGE INFORMATION
What is your preferred spoken language? Please select only ONE .
<input type="checkbox"/> Arabic <input type="checkbox"/> Haitian - Creole <input type="checkbox"/> Korean <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____
Do you require free interpreter services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written notices can be sent in the languages listed below. Please select only ONE . If your preferred language is not listed, please check (<input checked="" type="checkbox"/>) English.
<input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Haitian - Creole <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Spanish