Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)
APPLICATION FOR THE ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP)

Return your completed application to:
_____ County/City DSS
_____
_____

GENERAL INFORMATION

With this application, you may apply for food assistance if:

- Everyone in the household is 60 years of age or older; or
- All household members aged 60 or older purchase and prepare food separately from other household members; and
- No member receives earnings from work.

COMPLETING THE APPLICATION

If you need help completing this application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If there are more than 2 people living in your home and you need more space to list everyone, tell the agency you need extra pages. If you have a disability or have difficulty with English, you may receive extra help to make sure you get the assistance or services you are eligible to receive.

FILING THE APPLICATION

You may turn in a partially completed application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this application before your eligibility can be determined.** You must also be interviewed, but you may turn in your application before your interview. You may turn in your application any time during office hours the same day as you contact your local agency. You have the right to turn in your application even if it looks like you may not be eligible for benefits.

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers, may be matched against federal, state, and local records. These records include:

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System IEVS)
- Virginia Lottery

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:

- determine the correctness, accuracy, and truthfulness of the application;
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

Your information may also be used or disclosed to study public benefit programs, such as SNAP.

Information regarding your race and ethnicity is not required and will not affect your eligibility or benefit amount. This information is requested to be sure that program benefits are provided without regard to race, color, or national origin.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible. To qualify for Expedited Service: 1) your gross monthly income must be less than $150 and liquid resources $100 or less; 2) your monthly shelter bills must be higher than your household's gross monthly income plus your liquid resources; or 3) someone in your household must be a migrant or seasonal farm worker with little or no income and resources.

REPORTING REQUIREMENTS

You must report changes within 10 days, but no later than the 10th day of the month after the change occurs. Report these changes:

- If you have lottery or gambling winnings of $3,750 or more;
- If you have changes in the number of people in your household; or
- If you or a member of your household start to receive money from working.

SNAP RESPONSIBILITIES AND PENALTIES FOR VIOLATIONS

You must not:

- give false information or hide information to get SNAP benefits;
- trade or sell EBT cards or attempt to trade or sell EBT cards;
- use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products;
- use someone else's EBT card for your household.
- buy an item and discard the contents in order to get the return deposit for the container;
- resell a purchased product for cash or exchange a purchased product for consideration other than eligible food; or
- purchase food on credit.

If you intentionally break any of these rules, you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); fined up to $250,000, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

If you intentionally give false information or hide information about identity or residence to get SNAP benefits in more than one locality at the same time, you could be barred for 10 years.

If you are convicted in court of trading or selling SNAP benefits of $500.00 or more, you could be barred permanently.

If you are convicted in court of trading SNAP benefits for a controlled substance, you could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

If you are convicted in court of trading SNAP benefits for firearms, ammunition, or explosives, you could be barred permanently for the first violation.

If you refuse to cooperate with any review of eligibility, including a review by Quality Assurance, your benefits may be denied until there is cooperation.

Failure to report or verify your expenses will be seen as a statement that you do not want to receive a deduction for these expenses.

NONDISCRIMINATION STATEMENT

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights,1400 Independence Avenue, SW, Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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 State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

COMMONWEALTH OF VIRGINIA VOTER REGISTRATION AGENCY CERTIFICATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Please check only one)

- ❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ❑ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
- ❑ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, Telephone (804) 864-8901.

Applicant Name	**Signature**	**Date**

for agency use only

Voter Registration form completed: ❑ Yes ❑ No
Voter Registration form given to applicant for later mailing (at applicant's request) ❑ Yes ❑ No

Agency Staff Signature	Date:

Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)

APPLICATION FOR THE ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP)

Return your completed application to:
_____ County/City DSS
_____
_____

A. APPLICANT INFORMATION. Enter your Contact Information.

Your Name (last, first, middle initial)

Your Street Address (include apartment number) | **City, State, ZIP**

Your Mailing Address (if different from your street address) | **City, State, ZIP**

Email Address | **Primary Telephone Number** | **Alternate Telephone Number**

What is the primary language spoken in your household?

Primary Method of Correspondence

You may receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov). List either a cell telephone number or an email address. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

❑ **Text** ❑ **Email** **Cell Phone Number** _____ **Email Address** _____

❑ YES ❑ NO 1. Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving SNAP benefits from a social services agency? If **YES,** enter the information below.
When? _____ From What County, City, or State? _____

❑ YES ❑ NO 2. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive SNAP benefits in two or more states at the same time? If **YES**, give date and place of conviction._____

❑ YES ❑ NO 3. Have you or anyone for whom you are applying ever been disqualified from participating in SNAP? If **YES**, give date and place of all disqualifications._____

❑ YES ❑ NO 4. Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If **YES,** explain _____

❑ YES ❑ NO 5. Have you or anyone for whom you are applying ever been convicted as an adult on or after February 8, 2014 for the following:

a. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
b. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
c. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
d. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

6. You may appoint someone to apply for SNAP benefits on your behalf, receive and use your SNAP benefits on your behalf, or receive copies of your program notices. If you want to name a representative, please give the information below

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for SNAP benefits ❑ Receive correspondence ❑ Access or use SNAP benefits

B. HOUSEHOLD COMPOSITION: This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person. List yourself first. If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

1 | **Self** | _____

Name (last, first, middle initial) | **Relationship to You** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Are you a U.S. citizen?** ❑ Yes ❑ No

Program Requested: If No, immigration status: _____

❑ None ❑ ESAP **US Residency Date:** __/____/____

Alien Registration Number:_____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

2

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Program Requested: If No, immigration status: _____

❑ None ❑ ESAP **US Residency Date:** __/____/____

Alien Registration Number:_____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

❑ YES ❑ NO Are there others who live in your home? If **YES**,

Name of Person	**Relationship**	**Does this person buy/eat food with you?**
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

C. RESOURCES

1. Do you or anyone who lives with you have any of the following resources or assets? If **Yes,** please provide details below.

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
❑	❑	Cash $_____	❑	❑	Checking/Savings Accounts	❑	❑	Stocks or bonds
❑	❑	401K, 403B, etc	❑	❑	Certificate of Deposit (CD)	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Other

a.

Owner Name (last, first, middle initial) | Co-Owner Name (last, first, middle initial)

Name of Bank or Institution | Account Type | Account Number | $ Balance

Address of Bank or Institution

b.

Owner Name (last, first, middle initial) | Co-Owner Name (last, first, middle initial)

Name of Bank or Institution | Account Type | Account Number | $ Balance

Address of Bank or Institution

❑ YES ❑ NO 2. Has anyone received or expect to receive winnings of $3,750 or more from lottery or gambling? If **YES**, explain:

_____

❑ YES ❑ NO 3. Has anyone sold, transferred or given away any resources in the last 3 months? If **YES**, explain:

_____

D. INCOME

❑ YES ❑ NO 1. Do you or anyone applying for ESAP with you receive or expect to receive money from working? If **YES**,

Name of Person	$ Amount/ How Often Received?	Employer

2. Do you or anyone applying for ESAP with you receive or expect to receive any of the following? Answer yes or no below and provide the requested information.

Yes	No		Yes	No		Yes	No	
❑	❑	Social Security or SSI	❑	❑	Worker compensation	❑	❑	Room/board or Rental Income
❑	❑	VA benefits or Military Allotment	❑	❑	Unemployment benefits	❑	❑	Interest, dividends
❑	❑	Child support, alimony	❑	❑	Black Lung benefits	❑	❑	Public Assistance (TANF/GR)
❑	❑	Railroad or Other retirement	❑	❑	Insurance settlement	❑	❑	Any other type of money

	Name of Person	$ Amount	Type of Money or Help	How Often Received?
a.				
b.				

E. EXPENSES

❑ YES ❑ NO 1. Do you have any of the following shelter expenses? If **YES**, list your current expenses. Check (✓) here ❑ if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes/ Insurance			
Electricity			
Gas/Oil/Kerosene/Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Other			

❑ YES ❑ NO 1a Do you have air conditioning in your home? How do you heat your home? _____

❑ YES ❑ NO 1b Did you receive energy/fuel assistance during this past year while living in your current home?

❑ YES ❑ NO 2. Do you or anyone in your household who is age 60 or older have any current medical expenses? If **YES**, list the expenses. This may include prescriptions, health insurance premiums, transportation, or doctor visit payments.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

❑ YES ❑ NO 3. Does anyone <u>besides the people on your case</u> pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? <u>OR</u> does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

_____

❑ YES ❑ NO 4. Does anyone pay legally obligated child support to someone who is not in the household? If **YES**, give name of person paying, person supported, and amount: _____

_____

BY MY SIGNATURE BELOW, I DECLARE: I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud.

❑ **I allow** ❑ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, and the Department for Aging and Rehabilitative Services. I can withdraw this authorization at any time by notifying my eligibility worker.

_____ _____

Signature of Applicant or Authorized Representative **Date**

AGENCY USE ONLY	
Case Name	Case Number
Locality	Date Received
Date of Interview:	❑ In office ❑ Telephone
Interviewer	Program (s)