ACTION REQUIRED BY <Due Date>
<Client First MI Last Name><Suffix>
<Care of (c/o)>
<To Street Address Line1>
<To Street Address Line 2>
<To City, State, Zip>

Return to:
Department for Community Based Services
Nutrition Assistance and Accountability Branch
P.O. Box 2104
Frankfort, KY 40602

Elderly Simplified Application Project (ESAP) Recertification

To determine your household's continuing eligibility for the Elderly Simplified Application Project (ESAP), we need you to answer all the questions on this form. To avoid delays, return this form and supporting documents for any changes to DCBS by <Due Date>. If you need help to complete this form call <CallServiceNumber1>. **Your ESAP Benefits will end if you do not return this form and proof of changes entered by <Date>.**

Address:

Our current records show that you live at:

PHAddressLine11
PHAddressLine21
PHCity1, PHStateCode1 PHZipCode1

You can choose to have someone help you. You don't have to do this. But, if you do, this person can fill out your application, answer questions for you, give information at your interview, or buy your food with your EBT card. We will be able to share information with this person. **Note**: In-patient Drug and Alcohol Rehabilitation Centers **must** designate an employee to apply for any residents.
Representative:

_____
(Last Name) (First Name) (M.I.)

_____
(Mailing Address) (City) (State) (Zip Code)

Date of Birth _____/_____/_____ (_____)_____
MM DD YYYY Phone Number

1. Have you moved? ☐ Yes ☐ No

If yes, please complete the section below:

A. New address: _____

B. Mailing address: _____

C. Contact/phone number: _____

D. Email address: _____

2. Has anyone moved into or out of your household? ☐ Yes ☐ No

If yes, fill in the information on the chart below for anyone that has moved into or out of your household.

***** Ethnicity
H = Hispanic or Latino
N = Not Hispanic or Latino

**Race (Choose all that apply)
B = Black or African American
W = White
A = Asian
N = Native Hawaiian/other Pacific Islander
I = American Indian or Alaskan Native

Moved In/Out	Want SNAP/ ESAP? Y/N	First Name, M.I., Last Name	SSN	DOB	Relationship to You	Sex M/F	Age	Ethnicity*	Race**	Are you a U.S citizen, qualified immigrant or in a satisfactory immigration status?

3. Is anyone in your household currently serving a SNAP disqualification?

☐ Yes ☐ No

If yes, name of person(s): _____

4. Has anyone in your home been convicted of giving wrong information about who you are or where you live to get SNAP benefits in more than one household at a time since 8/22/96?

☐ Yes ☐ No

If yes, who: _____

5. Have you or any member of your household been convicted, as an adult, of aggravated sexual abuse, murder, sexual exploitation or other abuse of children, a federal or state offense involving sexual assault, or a similar offense under state law after February 7, 2014? ☐ Yes ☐ No

If yes, who: _____

Is the convicted member complying with the terms of the sentence? ☐ Yes ☐ No

6. Has anyone in your home been convicted of buying, selling or trading more than $500 in SNAP benefits since 8/22/96? ☐ Yes ☐ No

If yes, who: _____

7. Has anyone in your home been convicted of trading SNAP benefits for firearms, ammunition, or explosives since 8/22/96? ☐ Yes ☐ No

If yes, who: _____

8. Have you or anyone in your home been convicted of trading SNAP benefits for drugs after 8/22/96?
☐ Yes ☐ No

If yes, who: _____

9. Have you or any household member received lottery or gambling winnings? ☐ **Yes** ☐ No

If yes, please complete the section below:

Who: _____

When: _____

Amount received: _____

10. Has income changed for anyone in the household? ☐ Yes ☐ No

If yes, please complete the chart below:

Where the Money Comes From	Who Gets the Money	Amount per Month	Employer (if applicable)
Money From Work Before Taxes (Gross)			
Money From Work Before Taxes (Gross) 2nd Job			
Self-Employment or Odd Jobs			
Tips			
Social Security or SSI			
Veterans Benefits, Pensions or Retirement			
Unemployment or Worker's Compensation			
Child Support or Alimony			
Money from Friends or Relatives			
Other			

11. Any change in shelter or utility expenses? Yes ☐ No ☐
If yes, please complete the chart below:

	Yes	No	If YES, list monthly/yearly amount
Does your household pay mortgage?			
Does your household pay rent?			
Does your household pay property taxes on the home?			
Does your household pay homeowner's insurance?			
Does your household pay for heating or cooling costs?			
If your household does not pay heating or cooling costs, do you pay other utilities?			

12. Does your household pay out-of-pocket medical expenses over $35 per month? ☐ Yes ☐ No

If yes, complete the chart below. We will need proof of your medical expenses. You may be eligible to receive more benefits if your out-of-pocket medical expenses are greater than <$172> per month.

Person Who Has the Bill	Type of Expense (Doctor, Hospital, Prescriptions, Medicare Premium, transportation)	Date of Service	Amount Owed

13. Do you or someone in your household pay court-ordered child support? ☐ Yes ☐ No
If yes, who pays: _____ Amount: $_____ per month

What we do with your information
The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Supplemental Nutrition Assistance Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

I understand:

- The questions on this application and what can happen if I hide information or give wrong information.
- I must give proof of information about my household.
- The DCBS office and the Quality Control unit may contact other people or organizations to get proof of my information.
- That the information I have provided on the application including the information concerning citizenship and alien status is subject to verification by federal, state, and local officials to determine if the information is true.
- That as an applicant for SNAP benefits, I am required to provide a social security number for everyone who lives in my home for whom I am applying for benefits. (Social Security numbers and immigration status does not have to be provided for members that are not applying for benefits.)
- That social security numbers shall be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, Wage Records, Unemployment Insurance, Child Support Enforcement records and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits.

I agree:

- That all required members of my household will follow the work and training rules.

I certify, under penalty of perjury, that:

- My answers are correct and complete to the best of my knowledge.
- My answer about citizenship or alien status of each person applying for assistance is correct.

Signature	**Witness (If signed by X)**	**Today's Date**
		MM/DD/YYYY

Case Number: <Case no.>

Date: <Date>

Report Changes:

You must report the following changes no later than 10 days after the end of the month the change occurs:

- When the income for your household exceeds the gross income limit for your current household size; or
- When a member of your household age 18-49 years old, and subject to work requirements, begins to work less than 20 hours per week.
- When a member of your household receives lottery or gambling winnings of $4250 or more.

Call DCBS at 1-855-306-8959 to report any changes.

DCBS accepts calls between 8:00 a.m. and 4:30 p.m. EST Monday through Friday and between 9:00 a.m. and 2:00 p.m. EST on Saturday.

Follow these rules:

- Do NOT give false information or hide information to get SNAP benefits.
- Do NOT trade or sell SNAP benefits.
- Do NOT use SNAP benefits to buy ineligible items, like alcoholic drinks, soap, tobacco products, firearms, ammunition, explosives, or a controlled substance as defined by 21 U.S.C. 802.
- Do NOT use someone else's SNAP benefits for your household.
- Do NOT use your SNAP benefits for someone outside of your household.
- DO NOT use your SNAP benefits to pay on a credit account, even if it is for SNAP eligible food.
- Do NOT sell food purchased with SNAP benefits.

Penalties for breaking these rules:

You may be stopped from getting benefits and you may be prosecuted. You could be:

- Stopped from getting SNAP benefits for 1 year, 2 years, or permanently;
- Fined up to $250,000 or jailed up to 20 years, or both; and
- Stopped from getting SNAP benefits for 10 years if you are found guilty of giving wrong information about who you are or where you live.

Giving wrong information on purpose may result in us taking criminal or civil legal action against you. It might also mean we reduce your benefits or take money back from you.

You have the right:

- To quick action whenever you report a change.
- To get notice of any action.
- To give us information to show the proposed action should not be taken.
- To discuss your benefits with a worker.
- To receive fair treatment.

Complaints about your case? Call the Ombudsman at 1-800-372-2973 or (TTY) 1-800-627-4702.

You have rights under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act.

Call DCBS at 1-855-306-8959 if you have a physical or mental limitation, such as mental illness, trouble learning, drug or alcohol addiction, depression, moving around, hearing or seeing. Here are some ways we can help:

- We can call you if you are not able to come to our office;
- We can tell you what this letter means;
- If you cannot do something we ask, we can help you or change what you have to do;
- We can help you resolve problems without a hearing;
- We can help you request a hearing.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

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.

You may also file your complaint with the Cabinet for Health and Family Services by writing or calling:

Office of Human Resource Management
EEO Compliance Branch
275 E Main St 5C-D
Frankfort KY, 40621
1-502-564-7770 ext. 4107

How to get a Hearing:

Do you disagree with something **we have done** to your benefits? If so, you may ask for a hearing **within 90 days** from the date of this notice.

Want to continue your benefits?

Ask for a hearing **within 10 days** from the date of this notice. This may allow you to get the same benefits until the hearing officer makes a decision or your current certification period ends, whichever occurs first. You may have to pay back these benefits if the decision is not in your favor.

If you want your benefits to continue, please include the following sentence in your written request: "I want my same benefits continued."

How do I ask for a hearing?

Call DCBS at 1-855-306-8959; **OR**

Attach a separate sheet of paper to explain your reason for requesting a hearing, sign and date then:
Return to any DCBS office; **OR**
Return to:

Cabinet for Health and Family Services
Division of Administrative Hearings
Family and Children Administrative Hearings Branch
105 Sea Hero Rd, Suite 2
Frankfort, KY, 40601

What will happen at the hearing?

- You may tell your side of the story or bring a friend, relative, or lawyer to speak for you.
- You can bring witnesses and papers to help tell your story.
- The hearing officer will decide what the State will do after hearing both sides of the story.
- You will be told what to do if you disagree with the hearing officer's decision.