PA-100
(R. 09/22[~~10/17~~])
921 KAR 2:040

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support
Phone: 855-306-8959 Fax: 502-573-2007

APPLICATION/RECERTIFICATION FOR KTAP OR [~~K-TAP AND~~] KINSHIP CARE

Date _____ Case Name _____ Case Number _____

Check program type:
☐ KTAP [~~K-TAP~~] ☐ Kinship Care

1. Name _____
(First) (Middle Initial) (Last)

2. Home Address _____
(Street) (Apt. No.)

_____KY_____
(City) (Zip Code) (County)

3. Is mailing address different than home? ☐ Yes ☐ No If yes, list mailing address:

_____
(Street or P.O. Box) (Apt. No.)

_____
(City) (State) (Zip Code) (County)

4. Phone #: Home _____ Work _____ Cell _____

Other to leave message _____ Name _____

5. List all people [~~of the persons~~] who live in the home.

First Name	M.I.	Last Name	U. S. Citizen Y/N	SSN	Date of Birth	Sex	Relationship
							Self

6. Is anyone in your household currently enrolled in school [~~the individual or anyone living in the home pregnant~~]? Yes ☐ No ☐ If yes, complete the table below.

[~~Name _____ Expected Delivery Date _____~~

~~7. List the deprivation factor for each child included in the application.~~]

Member First, MI, Last Name [~~of Child~~]	[~~Deprivation~~]	Educational Institution [~~Name of Parent~~]	Highest Level Completed [~~Onset Date of Deprivation~~]

7. Is anyone blind, disabled, incapacitated, or unable to work? Yes ☐ No ☐ If yes, who? _____

8. Do the liquid resources (such as checking/savings or other bank accounts) of the individual, individual's spouse, or child(ren) total close to $10,000?
Yes ☐ No ☐ If yes, complete the table below:

Type of Resource(s)	Amount	Name and Address of Financial Institution	Member Name
	$		
	$		
	$		
	$		

9. List all household members who receive money from any source (such as Social Security, Unemployment Insurance, Railroad Retirement, Black Lung, SSI, Worker's Compensation, child support [~~Child Support~~], a job, rental income, cash payments, wages, self-employment, farm income, roomer/boarder, etc.).[~~?~~]

Person Receiving Income	Source of Income [~~Employer~~]	Type of Income	Amount Received Last Month	Amount Received This Month	Amount Expected Next Month	How Often Received (monthly, weekly, etc.)
			$	$	$	
			$	$	$	
			$	$	$	

10. Does anyone have no income? Yes ☐ No ☐ If yes, who? _____

[~~9. Does anyone pay any bills for the recipient or other individuals included in the application or provide for any expenses (e.g., food, clothing, shelter, utilities, etc.)? Yes ☐ No ☐ If yes, complete the following.~~

~~Type of Bill or Expense Paid~~	~~Amount Paid~~	~~How Often Paid~~	~~Date Last Paid~~	~~Who Pays Bill or Provides for this Expense (Name and Address)~~	~~Vendor Payment Yes~~	~~No~~]
	$					
	$					
	$					

11.[~~10.~~] Is anyone paying for out of home care for a dependent household member ([~~outside of the household paid to care for a household member who is a~~] child or disabled person)? Yes ☐ No ☐ If yes, who is paying for this care? _____ How much? _____
For whom? _____[~~what is the SSN of person paying for this care? _____~~]

12. Has anyone received TANF benefits from another state? Yes ☐ No ☐ If yes, who? _____ When? _____
What state? _____

13. Is anyone potentially eligible for entitled benefits (i.e. Social Security, Worker's Comp, Veteran's, UIB, etc.)?
Yes ☐ No ☐ If yes, who? _____ What type of benefits? _____

14. Will child care be needed if you or the other parent are required to participate in the Kentucky Works Program (KWP)? Yes ☐ No ☐

15. List the absent parent for each child included in the application.

Name of Child	Name of Parent(s) Not in the Home	Deceased? Yes or No

16. Do you agree to assign child support rights to the Cabinet for Health and Family Services (CHFS)? Yes ☐ No ☐

17. Do you agree to cooperate with Child Support Enforcement? Yes ☐ No ☐

18. Do you agree to register for work? Yes ☐ No ☐

[~~11. Does a household member pay child support for children who are not in the home?~~

~~Yes ☐ No ☐ If yes, name of member who pays: _____ How much? $_____ How often? _____~~

~~Does a household member pay alimony? Yes ☐ No ☐ If yes, name of member who pays _____~~

~~How much? $ _____ How often? _____~~

~~Does a household member claim children in the home as dependents for federal income tax purposes? Yes ☐ No ☐ If yes, list names of children claimed.~~ _____

~~12. Check "yes" or "no" if individual, individual's spouse or children have any of the following liquid resources. If "yes", complete the remaining columns.~~

~~Type of Resources~~	~~Yes No~~	~~Amount~~	~~Name and Address of Financial Institution~~	~~Member Name~~
~~Checking Account~~	~~☐ ☐~~	~~$~~		
~~Savings Account~~	~~☐ ☐~~	~~$~~		
~~Certificates of Deposit, Stocks, Savings Bonds, or Other Bonds $~~	~~☐ ☐~~	~~$~~		
~~Other Cash Not Listed Above~~	~~☐ ☐~~	~~$~~		
~~Other Resources~~	~~☐ ☐~~	~~$~~		

~~13. List any liquid resources the individual, individual's spouse or children have traded, sold or given away within the past 24 months.~~

~~Type of Resource Traded, Sold, or Given Away~~	~~Date of Transfer~~	~~Assessed Value~~	~~Who Received this Resource~~	~~Amount Paid or Received~~
		~~$~~		~~$~~
		~~$~~		~~$~~
		~~$~~		~~$~~

~~14. Is anyone awaiting a settlement from an accident? Yes ☐ No ☐ If yes, answer the following questions. Who is expecting the settlement? _____ What type of settlement is it? _____~~

~~How much? $_____ When does this person expect to receive the settlement? _____~~

~~15. ***Complete form PAFS-706 for the individual who is applying and provide a hardcopy voter registration form.***~~

~~16. Have there been or does the individual expect any changes in the following areas: someone starting or quitting work; changing jobs; getting a raise; changing a name; getting married; starting or quitting school or training; moving in or out of the home; changing address (even if not moving); change in resources? Yes ☐ No ☐ If yes, list the changes.~~

~~Who _____ Change _____ When _____~~

~~Who _____ Change _____ When _____]~~

APPLICANT RIGHTS

You have the right to request a fair hearing before an impartial hearing officer if you are dissatisfied with any action or inaction concerning your case in accordance with 921 KAR 2:055. Request a fair hearing by calling 1-855-306-8959, from your personal page at kynect.ky.gov/benefits, by [~~or~~] writing any DCBS office, or by writing to the Division of Administrative Hearings, Families and Children Administrative Hearings Branch, 105 Sea Hero Rd. Suite 2, Frankfort, Kentucky 40601.

If you think you have been discriminated against because of your race, color, religion, sex (including gender identity and sexual orientation), national origin, religious creed, [~~or~~] disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity, you may file a complaint with the Office of Human Resource Management, EEO Compliance Branch at 275 East Main Street, 5C-D, Frankfort, Kentucky 40621, or call (502) 564-7770, ext. 4107[~~4548~~].

You may also file a complaint with the U.S. Department of Health and Human Services (HHS), HHS Director, Office of Civil Rights, [~~Room 515-F,~~] 200 Independence Avenue SW, H.H.H. Building, Room 509-F, Washington, DC 20201, or 1-800-368-1017 or (TTY) 1-800-537-7697 [~~call 202-619-0403 (voice) or 1-800-537-7697 (TTY)~~].

If you have complaints about your case, you can call the Office of the Ombudsman and Administrative Review [~~Ombudsman's Office~~] at 1-800-372-2973 or (TTY) 1-800-627-4702.

RESPONSIBILITIES AND SIGNATURE

I understand that the Social Security Act requires that all recipients of assistance furnish and be identified by a social security number, and if an individual refuses to apply for a number, [~~that~~] the department [~~Department~~] cannot make a payment. I understand that I do not have to provide a social security number and immigrant [~~alien~~] status for individuals in my house for whom benefits are not being applied. I understand that social security numbers shall be used for various state [~~State~~] and federal [~~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, and other matches [~~as provided under the authority of IEVS~~]. This information may be verified through collateral contact when discrepancies are found. Information provided through these matches [~~under IEVS~~], after verification, may affect eligibility for and amount of benefits. This information shall be disclosed to other agencies only as permitted by law.

I understand that if I receive Kentucky Temporary Assistance Program (KTAP) or [~~(K-TAP),~~] Kinship Care Program benefits for children whose parent is [~~voluntarily~~] absent, I am required to cooperate in child support activities. If I receive KTAP [~~K-TAP~~] or kinship care, [~~Kinship Care~~] I shall send all support payments to the cabinet [~~Cabinet~~] within 10 days of receipt. Failure to forward all payments may result in a decrease in KTAP [~~K-TAP~~] or kinship care, [~~Kinship Care~~] benefits, and procedures for collection may be started against me.

[~~RESPONSIBILITIES AND SIGNATURE (continued)~~]

I understand that by receiving KTAP [~~K-TAP~~], all adult members of my case are required to participate in [~~automatically registered with~~] the Kentucky Works Program (KWP). If required to register for job services and seek employment, I agree to cooperate with specified responsible agencies. I give my consent to the Department for Community Based Services and specified responsible agencies to track my employment for statistical purposes.

I understand that I cannot use the EBT card for any cash benefit transaction or ATM withdrawal at liquor stores, adult-oriented entertainment facilities, or any casino, gambling casino, or gaming establishments.

I declare that all persons for whom application is made are U.S. citizens [~~Citizens~~] or are admitted under approved immigrant [~~alien~~] status. I certify under penalty of perjury, the information, including citizenship or immigrant [~~alien~~] status, provided by me in this statement is correct and true to the best of my knowledge.

I hereby give my consent to the Department for Community Based Services and the Office of the Inspector General to make necessary contacts to verify statements made by me in this application.

I understand that I shall report all changes in circumstances and income to DCBS by calling 1-855-306-8959 within 10 days from the day I become aware of the change.

I understand that if I give false information, withhold information or fail to report changes within 10 days, I may be subject to prosecution for fraud, reduction, or loss of benefits, and I may be required to repay benefits I receive.

Your Signature: _____ Date: _____

[~~Spouse's Signature: _____ Date: _____~~

~~Authorized Representative Signature _____ Date _____~~]

Witness, if signed with an X: _____ Date: _____

COMMENTS