

Information Booklet

Michigan Department of Health and Human Services

Read this booklet before you sign the Assistance Application.



Healthcare Coverage

Standard processing: within 45-90 days.



Food Assistance Program (FAP)

Provides benefits to buy or grow food.

Expedited processing: within 7 days.

Standard processing: within 30 days.



Cash Assistance

Family Independence Program (FIP)

For pregnant women or families with children.

Standard processing: within 45 days.

Refugee Cash Assistance (RCA)

For people admitted to the U.S. as refugees or someone treated as a refugee.

Standard processing: within 30 days.

State Disability Assistance (SDA)

For adults with disabilities, live-in caretakers, or people in a special living arrangement.

Standard processing: within 60 days.



Child Development + Care (CDC)

Helps pay for childcare.

Standard processing: within 30 days.



State Emergency Relief (SER)

Provides help or assistance for emergency situations.

Standard processing: within 10 days.



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الن تمييز ادارة الخدمات الصحية و الانسانية لولاية ميشيغان Michigan Department of Health and Human Services (MDHHS) ضد أي فرد أو مجموعة بسبب العرق، أو الديانة، أو العمر، أو الأصل الوطني، أو اللون، أو الطول، أو الوزن، أو الحالة الزوجية، أو المعلومات الجينية، أو الجنس، أو التوجه الجنسي، أو الهوية الجنسية أو التعبير، أو المعتقدات السياسية، أو الإعاقة.

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Healthcare Coverage

Overview

Healthcare coverage provides help to pay for the costs of:

- Affordable private health insurance plans that offer comprehensive coverage.
- A new tax credit that can immediately help pay premiums for health coverage.
- Free or low-cost insurance from Medicaid, Healthy Michigan Plan, or MIChild (Children's Health Insurance Program).

Even if you have insurance, there might be a program with better coverage or lower costs.

Did you consume water from the Flint Water System and live, work or receive childcare or education at an address that was served by the Flint Water System from April 2014 through present day? If yes, you may wish to apply for health care coverage at www.michigan.gov/mibridges or request a DCH-1426, Application for Health Coverage & Help Paying Costs.



Who is eligible?

In Michigan, there are many healthcare programs available to children, adults and families.

- Use the application to apply for anyone in your family.
- Apply even if you or your child has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your eligible immigration status or chances of becoming a permanent resident or citizen. Undocumented individuals can be reported to United States Immigration and Customs Enforcement (ICE).

To be eligible for coverage, parents requesting healthcare coverage for themselves must provide proof that the children have credible coverage, even if not applying for the children. Credible coverage is health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service, the Peace Corps; public health plan (any plan established or maintained by a state, the United States government or a foreign country); Children's Health Insurance Program (CHIP); or, a state health insurance high risk pool.

Who do I need to include on the application?

Complete the application for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can.

If an adult is applying for coverage, include all of these people (even if they aren't applying for health care coverage themselves):

- Any spouse.
- Any son or daughter under age 21 they live with, including stepchildren.
- Any other person on the same federal income tax return (including any children over age 21 that are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

If a youth or child under age 21 is applying for coverage, include all of these people (even if they aren't applying for health coverage themselves):

- Any parent (or stepparent) they live with.
- Any sibling they live with.
- Any son or daughter they live with, including stepchildren.
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

To get help with your application, visit our website: www.michigan.gov/mibridges or call the application help line at 855-276-4627. You can also call the Beneficiary Help Line at 800-642-3195 or TTY 866-501-5656.

To purchase insurance through the Marketplace visit: www.healthcare.gov.



How are benefits calculated?

The amount of assistance or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility could be affected.

What happens next?

If you don't have all the information we ask for, sign and submit your application anyway. We'll follow up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call our application help line at 855-276-4627 or 800-642-3195. Filling out an application doesn't mean you have to buy health coverage.

Additional program policies

Renewal of coverage in future years

To make it easier to determine your eligibility for help paying for health coverage in future years, you can agree to allow the Marketplace and the state of Michigan to use income data, including information from tax returns. The Marketplace and the state of Michigan will send you a notice and let you make any changes. You can opt out at any time.

If anyone on this application is eligible for Medicaid, Healthy Michigan Plan, or MICHild

You are giving MDHHS the rights to pursue and get any money from other health insurance, legal settlements or other third parties. You are also giving to MDHHS rights to get medical support from a spouse or parent. If you believe getting medical support from a spouse or parent will harm you or your child, tell your MDHHS specialist. You may have a good cause reason to not help with your case.

[To claim good cause, tell your MDHHS specialist now.](#)

Medicaid estate recovery (MA - Long Term Care (LTC))

You understand that upon your death MDHHS has the legal right to seek recovery from your estate for services paid by Medicaid (including Healthy Michigan Plan). This means that some or all of your estate may be recovered. MDHHS will not seek to recover against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, or blind or disabled. An estate consists of real and personal property. If you have received an asset disregard due to a long-term care partnership policy, the amount disregarded will be subtracted from the amount sought under Estate Recovery. In these situations, Estate Recovery applies to all assets whether they are subject to probate administration or not. Estate Recovery only applies to certain Medicaid and Healthy Michigan Plan recipients who received services after the effective date of the estate recovery statute. MDHHS may agree not to pursue recovery if an undue hardship exists.



An application must be submitted to determine if the applicant qualifies for an undue hardship waiver. Undue hardship waivers are temporary. For further information regarding Estate Recovery or to request an undue hardship application, call 800-642-3195.

Coordination of health care programs and providers (MA)

The State's medical assistance program relies on a large number of managed care health programs, mental health and substance abuse programs and private providers to deliver quality care to individuals like you. To make sure you receive a high level of care and that your benefits are coordinated, providers in the program may share information about your care (or your child or ward) with other providers in the program when such information and consultation are clinically needed.

Information about you, your child or ward (MA)

Necessary information may be shared between health plans and programs in which you participate. Health plans, programs and providers that deliver healthcare to you may share necessary information in order to manage and coordinate health care and benefits. This information may include, when applicable, information relative to HIV, AIDS, AIDS-related complex (ARC) or other communicable diseases, information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse as permitted by 42 CFR Part 2.

Your right to appeal

If you think the Health Insurance Marketplace or Medicaid, Healthy Michigan Plan or MICHild has made a mistake, you can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace, Medicaid, Healthy Michigan Plan or MICHild that you think the action is wrong, and ask for a fair review of the action. Contact the Marketplace at 800-318-2596 or see "Resources" for details on how to request a hearing.

Food Assistance Program (FAP)

Overview

FAP provides benefits to buy or grow food for your household.

Who is eligible?

You may qualify for the food assistance program if you have low income and \$5,000 or less in assets.

Expedited Food Assistance: Your household may qualify for 7 day processing of your FAP application if:

- Your monthly income (before taxes) is less than \$150, and you have \$100 or less in cash/accounts right now; **or**
- Your household's combined monthly income (before taxes) and cash/accounts are less than your household's combined monthly rent/mortgage and utilities; **or**
- You are a migrant or seasonal farmworker whose income has stopped, and you have \$100 or less in cash/accounts right now.

If you qualify for 7 day processing, you must participate in an interview, provide proof of your identity and complete the entire application.

To continue receiving food assistance benefits, you will be asked to provide proof of other information (like income, residency, etc.) within 30 days. If you provide the proof when you apply, you may be given a longer food assistance benefit period.

Most FAP interviews are held by telephone. However, you may request an in-person interview. If you are also applying for cash assistance, you may be scheduled for an in-person interview.



How are benefits calculated?

Eligibility and benefit amounts are calculated based on the number of people in your FAP household and your household income (subtracting some deductions and allowable expenses).

Deductions from countable income include:

- 20 percent of earned income; **and**
- A standard deduction based on the number of people in your FAP group.

Allowable expenses include:

- Medical expenses over \$35 a month that are not paid by a third party (only for people age 60 and older, a veteran with a disability, or a person with a disability).
- Some housing and utility costs.
- Some child care costs and costs for care of persons with disabilities.
- Court-ordered child support paid to a non-household member.

Failure to report or verify any listed expenses will be seen as a statement by you that you do not want to receive a deduction for the unreported or unverified expenses. Verifications must be received within 10 days.

Tell us on your application if you have received the Home Heating Credit (HHC) or a Michigan Energy Assistance Program (MEAP) Payment in an amount greater than \$20 in the last year. If you do not tell us about the credit, we will assume you do not want to receive a deduction for heat expenses.

What are my program responsibilities?

1. Cooperate with Child Support to provide information

MDHHS will enroll you in the child support program if a child in your home receives food assistance and one or both of the child's parents does not live in your home. Child support services will help you, if needed, to establish a legal father and/or get a support order for your child. The Office of Child Support will send you a letter with directions. You must help child support workers with your child support case by 1) giving them information they ask for and 2) going to appointments about your child support case.

If you do not help, you may lose some or all of your food assistance. If you believe helping with your case will harm you or your child, tell your MDHHS specialist. Your MDHHS specialist will determine if you have a good cause reason to not help with your case. Some examples of good cause reasons are rape, incest, history of abuse. There are other good cause reasons.

To claim good cause, tell your MDHHS specialist now.

2. Follow work rules

All group members who don't meet an exception to the work rules (see below) will be registered for work and may be required to perform specific work activities including cooperation with employment and training activities. Specific work requirements will vary depending on whether you receive cash assistance (FIP or RCA) or have time-limited FAP benefits (if you receive both cash and food benefits, you must follow FIP work rules).

If you are already working, you are not allowed to:

- Quit a job of 30 hours or more per week without good cause.
- Voluntarily reduce work hours below 30 hours per week without good cause.

If you are not working, or you work less than 30 hours per week, you are not allowed to:

- Refuse a suitable job offer.
- Refuse to participate in required employment-related activities that must be done to receive FAP.



What happens if I break work rules?

If you receive FAP and you break the work rules without good cause, your benefits will stop or be reduced for at least 1 month (first time) and 6 months (for any time after that). Reasons for a good cause include:

- An unplanned event or factor that does not allow you to meet the work rules (for example, domestic violence, religion, health or safety risk, or homelessness).
- Illness or injury.
- Lack of child care.
- Lack of transportation.
- Long commute (more than 2 hours per day or more than 3 hours per day with child care).
- You quit a job to take a comparable job.
- Your job required you to commit illegal activities.
- You are physically or mentally unable to do the job.
- Your employer discriminated against you based on age, race, religion, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability.
- You are working 40 hours per week for at least the state minimum wage.
- Reasonable accommodation was not provided.
- You are deferred.
- You moved due to another household member's job or education/training.
- You have a job that requires you to retire or join, resign from, or refrain from joining a labor union or organization.
- Have a job that is on strike or at a lockout state.
- Have unreasonable work conditions.
- Have been offered a job that is outside of your work experience during the first 30 days as a mandatory FAP work participant.
- Employer is not able to keep the promise of work.

If you think you have a good cause reason, contact your MDHHS specialist right away.

What are the exceptions to the work rules?

Some people who receive food assistance may be excused from work rules - if you think you should be excused, talk to your MDHHS specialist.

You may be excused from FAP work rules if you are:

- Under the age of 16.
- Age 60 or older.
- Personally caring for a child under the age of 6.
- Working 30 hours per week or earning at least the federal minimum wage times 30 hours per week.
- Attending high school, adult education or a GED program.
- Physically or mentally unfit for work.
- Personally caring for an incapacitated person.
- Applying for FAP at a Social Security office.
- In substance abuse treatment or rehabilitation.
- Applying for or receiving unemployment benefits.
- Appealing the denial of unemployment benefits.

Reasons for being excused may change.



Time-limited food assistance rules

Special time limits and work requirements might apply to you if you are:

- A person without a disability;
- At least 18 years old but under the age of 50; **and**
- Living in a household with no children under the age of 18 (related or unrelated).

Time limits are not always in effect, so check with your MDHHS specialist.

Cash Assistance

Overview

The main goal of cash assistance programs is to help families become self-supporting and independent.

- Family Independence Program (FIP) is temporary cash assistance for pregnant women or families with minor children.
- Refugee Cash Assistance (RCA) is temporary cash assistance for persons recently admitted into the United States as refugees or someone treated as a refugee.
- State Disability Assistance (SDA) provides cash assistance for adults with disabilities, live-in caretakers, people in a special living arrangement, or people age 65 and older.

Who is eligible?

You may qualify for cash assistance programs if you have low income, \$3,000 or less in cash assets, and \$200,000 or less in property assets.

FIP: You may be eligible for FIP if you are either a pregnant woman or a parent, legal guardian, or relative acting as a parent for a child under the age of 18 (or a high school student age 18). You cannot receive FIP for more than the federal 60 month time limit or the state's 48 month lifetime limit unless you qualify for an exception or exemption month (ask your MDHHS specialist for details). This includes any cash assistance you may have received in another state.

RCA: You may be eligible for RCA if you are a refugee (or someone treated as a refugee) as determined by the United States Citizenship and Immigration Services (USCIS) within eight months of date of entry to the United States, and not eligible for FIP.



SDA: You may be eligible for SDA if you are not eligible for FIP and you are 65 or older, or permanently or temporarily disabled, or taking care of a person with a disability who lives with you. Individuals may be considered disabled if they are:

- Age 65 or older.
- Unable to work for 90 days or more because of a medical condition.
- Receiving Supplemental Security Income (SSI) or Social Security disability benefits.
- Receiving medical assistance based on disability or blindness.
- Receiving special education services.
- Receiving help from Michigan Rehabilitation Services.
- Diagnosed as having AIDS.
- Living in an adult foster care home, a home for the aged, a county infirmary, a substance abuse treatment center, or a post substance abuse treatment center.

How are benefits calculated?

The FIP or RCA grant amount is based on:

- Number of people in your household group.
- Court-ordered child support expenses paid by your household.
- Total income.

What are my program responsibilities?

1. Cooperate with Child Support to provide information (FIP only)

MDHHS will enroll you in the child support program if a child in your home receives FIP and one or both of the child's parents does not live in your home. Child support services will help you, if needed, establish a legal father and/or get a support order for your child. The Office of Child Support will send you a letter with directions. You must help child support workers with your child support case by: 1) giving them information they ask for and 2) going to appointments about your child support case.

If you do not help, you may lose your FIP. If you believe helping with your case will harm you or your child, tell your MDHHS specialist. Your MDHHS specialist will determine if you have a good cause reason to not help with your case. Some examples of good cause reasons are rape, incest, history of abuse. There are other good cause reasons.

To claim good cause, tell your MDHHS specialist now.

You cannot get child support payments and FIP at the same time. While you get FIP, your child support payments will go to MDHHS. That support is used to repay MDHHS for the cash it gives you.

If MDHHS receives more in child support than it gives you in FIP for at least 2 months, MDHHS may close your FIP so you can get child support directly.

2. Immunize your children (FIP only)

Children under age 6 must be immunized as recommended by MDHHS. Your cash benefits may be reduced by \$25 per month until your children are up-to-date on their immunizations. A child is exempt from the immunization requirement if they are under 2 months of age, immunizations are medically inappropriate for the child, or immunizations are against the family's religious beliefs.

3. Send your children to school (FIP only)

Children ages 6–18 must attend school full-time.



4. Agree to Repay Agreements (FIP and SDA)

If you receive SDA, you agree to repay MDHHS if you receive lump sum payments (such as an inheritance, insurance settlement, etc.) or benefits that are paid retroactively (such as unemployment benefits or workers' compensation).

If you receive SDA or state-funded FIP and receive a lump sum SSI payment, the Social Security Administration (SSA) may automatically take the money you received while your SSI application was pending out of your first check and reimburse MDHHS. If MDHHS is not reimbursed in the first check you receive, you agree to repay MDHHS right away.

If you disagree with the amount MDHHS keeps, see “Resources” for details on how to request a hearing.

5. Follow work rules (FIP and RCA only)

FIP work rules:

- Complete a Family Automated Screening Tool (FAST).
- Develop and comply with a Family Self-Sufficiency Plan (FSSP): The FSSP will list the work activities that you must do up to 40 hours per week to receive FIP. You design this plan with your MDHHS specialist and the work participation program.
- Do not quit, refuse work or reduce work hours.
- Do not get fired from a job due to misconduct or missing work.

RCA work rules:

- Develop and comply with a Refugee Family Self-Sufficiency Plan (RFSSP).
- Do not quit, refuse work or reduce work hours.
- Do not get fired from a job due to misconduct or missing work.

What happens if I break work rules?

If you receive FIP or RCA and break the work rules without good cause (see good cause reasons below), MDHHS will:

- Deny your application (you may reapply).
- Stop FIP for your whole family for 3 months for the first time, 6 months for the second time and permanently for the third time.
- Count all penalty months toward your state 48 month lifetime limit (FIP only).
- Stop RCA for you for at least 3 months (but the rest of your household might be eligible).
- If you receive both FIP and FAP, we may stop or reduce your FAP benefits for at least 1 month if you are not excused from FAP work rules and count your FIP grant amount as income.

Good cause reasons

Reasons for a good cause include:

- An unplanned event or factor that does not allow you to meet the work rules (for example, domestic violence, religion, health or safety risk, or homelessness).
- Illness or injury.
- You requested child care that was not provided.
- You requested transportation services that were not provided.
- Long commute (more than 2 hours per day or more than 3 hours per day with child care).
- You quit a job to take a comparable job.
- Your job required you to commit illegal activities.
- You are physically or mentally unable to do the job.
- Your employer discriminated against you based on age, race, religion, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability.
- You are working 40 hours per week for at least the state minimum wage.
- Reasonable accommodation was not provided.

If you think you have a good cause reason, contact your MDHHS specialist right away. Reasons for good cause may change.



What are the exceptions to the work rules?

Some people who receive cash assistance may be excused from work rules. If you receive FIP and are excused from the work rules, you may have to do other activities. If you think you should be excused from work rules, talk to your MDHHS specialist.

You may be excused from FIP or RCA work rules if you are:

- Age 65 or older.
- A parent of a baby less than 2 months old. You may be assigned to family strengthening activities once the baby is 6 weeks old.
- Working 40 hours per week.
- Caring for a child or spouse with a disability (depending on the person's needs and the child's school attendance).
- A person with a disability or medical limitations.
- Experiencing a domestic violence situation (determined by MDHHS).

Child Development + Care (CDC)

Overview

CDC helps pay for the cost of child care for those who need it due to:

- Work.
- High school completion classes (including General Educational Development (GED), adult basic education and English as a second language).
- Approved education or training.
- Approved treatment activities for a health or social condition.

The CDC Handbook (which contains all of the program guidelines for parents and providers) can be found at: www.michigan.gov/childcare.

Who is eligible?

- A family with low income.
- A licensed foster parent requesting care for foster children.
- A member of a MDHHS protective services case participating in a treatment plan.
- A FIP or Supplemental Security Income (SSI) recipient.
- A FIP applicant doing a required work participation program activity.

If you are eligible at the date of your application, you will be able to keep your CDC benefits for the next 12 months. There are some exceptions.



How are benefits calculated?

The income eligibility scale and reimbursement rates can be found at: www.michigan.gov/childcare.

The actual CDC payment amount may not cover all child care expenses. You are responsible for any child care costs not covered by the CDC program.

You are responsible for any child care expenses before your case is approved and the child care provider is added to your case.

The department may request information from you at any time to verify your provider's billing. If overpayment is made to the child care provider for any reason, the provider must repay the extra payments.

The department may reduce future payments to the provider by up to 20 percent.

How do I select a childcare provider?

The child care you choose must be provided in Michigan by a:

- Licensed child care center.
- Licensed group child care home.
- Registered family child care home.
- Michigan Department of Education (MDE) enrolled unlicensed child care provider who has completed the Great Start to Quality Orientation and provides care in the child's home or is related by blood, marriage or adoption as a grandparent/great-grandparent, aunt/ great-aunt, uncle/great-uncle or sibling and provides care in his/her own home.

If you need help finding an eligible child care provider, contact your Great Start to Quality Resource Center at 877-614-7328 or visit www.greatstarttoquality.org.

To apply to be an unlicensed provider, complete the application at www.michigan.gov/childcare and follow the instructions listed on the application. If you use a friend or family member as a provider, the payments will be issued to you, and you will be responsible for paying the provider.

You are also responsible for reporting payments to the Internal Revenue Service (IRS) and issuing either a W-2 or 1099-MISC if appropriate.



What are my program responsibilities?

Cooperate with Child Support to provide information

MDHHS will enroll you in the child support program if a child in your home receives CDC assistance and one or both of the child's parents does not live in your home. Child support services will help you, if needed, establish a legal father and/or get a support order for your child. The Office of Child Support will send you a letter. Follow the directions in the letter. You must help child support workers with your child support case by 1) giving them information they ask for and 2) going to appointments about your child support case.

If you do not help, you may lose some or all of your CDC assistance. If you believe helping with your case will harm you or your child, tell your MDHHS specialist. Your MDHHS specialist will determine if you have a good cause reason to not help with your case. Some examples of good cause reasons are rape, incest, history of abuse. There are other good cause reasons.

To claim good cause, tell your MDHHS specialist now.

State Emergency Relief (SER)

Overview

SER provides limited help to households with low income that have an emergency that threatens their health or safety. Covered services include:

- Relocation payments to avoid or eliminate homelessness.
- Mortgage, insurance and/or property tax payment to stop forfeiture, foreclosure or tax sale.
- Limited home repairs.
- Home heating, electric and utility bills.
- Burial costs.

For energy related emergencies, the SER crisis season runs from Nov 1 through May 31. Requests for those services will be denied June 1 through Oct 31.



Who is eligible?

You may qualify for SER if:

- You have low income and limited assets.
- The emergency situation is not likely to happen again (example: for help with rent or house payments, you must show you have enough income to pay your housing costs in the future).
- You have made certain required payments on your shelter, heat, electric and/or utility bills.

How are benefits calculated?

The amount of help you may receive depends on the number of people in your household, income, assets, type of service requested and other factors.

Your Responsibilities

By signing your application, you are agreeing to fulfill these responsibilities.

In order to get and keep benefits, it is your responsibility to...

Release information for program needs

You consent to the gathering, use and disclosure of your information by MDHHS and third parties. You understand the information is needed for the purpose of providing benefits or services, obtaining payment for your benefits or services, and for normal business operations of the department. You release the department from all liability for sharing this information with other agencies for this purpose. See “Privacy Details” on page 39 for examples of information that MDHHS will get from others and give to others.

Tell the truth

You are responsible for providing information on this application that is true and accurate. You could be sanctioned if you have intentionally given false or misleading information, or hidden/withheld facts that may cause you to receive assistance you should not receive or more assistance than you should receive. Sanctions may include administrative, civil or criminal actions, including prosecution. See “Penalties” on page 41 for details.

Use your benefits legally

It is illegal to give your FAP benefits or Bridge card away or to trade the benefits on your card for cash, lottery tickets, firearms, drugs, or other goods and services. Benefits that are sold or traded are treated as extra benefits and must be repaid. Penalties include fines, imprisonment and disqualification from future benefits. If you receive cash assistance, it is prohibited to use FIP, RCA, or SDA to purchase lottery tickets, alcohol, tobacco, or for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond activities, adult entertainment, cruise ships or other nonessential items. See “Penalties” on page 41 for details.



Repay any benefits you should not have received

If you or anyone in your household receives benefits they are not eligible for, the adults in the household must repay the extra benefits. The benefits must be repaid even if there was no fraud. If the department makes an error, the adults in the household must repay the extra benefits. For FAP, an authorized representative (who has access to your benefits and can shop for you) may also be responsible for repayment of any extra FAP benefits. MDHHS may keep part of your future benefits as repayment for extra benefits you received. If you disagree with the amount MDHHS keeps, see “Resources” on page 37 for details on how to request a hearing.

Cooperate with Child Support to provide information

If you are receiving Medicaid, FAP, FIP and/or CDC assistance, you must help child support workers with your child support case by 1) giving them information they ask for and 2) going to appointments about your child support case. If you do not help, you may lose some or all of your benefits. If you believe helping with you case will harm you or your child, tell your MDHHS specialist. Your MDHHS specialist will determine if you have a good cause reason to not help with your case. Some examples of good cause reasons are rape, incest, history of abuse, or threats of abuse. There are other good cause reasons. **To claim good cause, tell your MDHHS specialist now.**

Report changes

You are responsible for telling the department of any changes to the information you provided. **These changes should be reported as soon as they happen, but no later than within 10 days of the change.** For FIP only, you must report a child leaving your home within 5 days (if they will be absent for 30 days or more). If you do not report a change, you may be prosecuted for fraud or denied benefits. See “Resources” on page 36 for details on how to report changes.

Your MDHHS specialist will tell you if different reporting rules apply to you, such as simplified reporters.

Cooperate with state or federal reviewers

You may be required to cooperate with state or federal reviewers who are making sure your benefits are correct. You may not be eligible to receive benefits if you do not cooperate.

Pursue other benefits that you may qualify for

For most programs, you must apply for other benefits you may qualify for, such as unemployment benefits, Social Security and Supplemental Security Income (SSI) benefits and Veterans Administration benefits. MDHHS will tell you if you need to apply for benefits. If you do not pursue benefits when required, your MDHHS benefits may be reduced, closed or denied.

Provide Social Security numbers (SSN)

For most programs, under federal law 42 USC 1320b-7, you must provide Social Security numbers. You do not need to provide Social Security numbers for household members who are not applying (with the exception of SER), adults applying for child care, or FAP recipients who cannot provide or obtain a Social Security number based on religious grounds. MDHHS will use Social Security numbers to check whether you are eligible and receiving the correct benefits.

If you are applying for a Social Security number, give MDHHS the Social Security number as soon as you receive it. If you do not, your benefits may be reduced or denied. For healthcare coverage, providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit [socialsecurity.gov](https://www.socialsecurity.gov), or call Social Security at 800-772-1213. TTY users should call 800-325-0778.

Provide proof

For most programs, you will have to provide papers that show what you've told the department is true. You must give the department all requested papers and documents before your eligibility for benefits can be determined. If you do not provide proof, your application may be denied.

Report any tribal benefits that you receive

You cannot receive food benefits from the tribal food distribution program and the food assistance program at the same time. You cannot receive tribal TANF (cash) from a tribe and FIP cash benefits from MDHHS at the same time. Tribal organizations may receive Low Income Home Energy Assistance Program (LIHEAP) funds from the federal government. Payments are limited to the highest amount available from either MDHHS or the tribal organization. MDHHS will ask you to prove any tribal LIHEAP payment you receive.

Your Rights

Your general application refers to this page when signing your application for submission.

No matter who you are, you have the right to...

Ask for a hearing

You have the right to request a hearing if you do not agree with any action or decision the department makes (including failure to act with reasonable promptness). You can ask for a hearing for FAP by phone. Hearings for all other programs must be requested in writing. At the hearing you can explain why you think the action is wrong and present evidence.

You may have your assistance continued if you file your request for hearing within 10 days of the denial notice. You may be required to repay any assistance that you receive while your appeal is pending if 1) the department's proposed action is upheld in the hearing decision, or 2) your request for appeal is withdrawn, or 3) you or your authorized representative do not attend this hearing.

A hearing will be granted if we receive your request for an appeal within 90 days of the date an action was taken by MDHHS or loss of your benefits. MDHHS must receive your request for an appeal within 10 days of the mailing date of the notice to continue receiving your benefits.

You may choose anyone to represent you. If that person is not a lawyer or is not appointed by a court, you must give us your signed authorization. Attach a copy of the court's order if the person is court-appointed to help you. The Michigan Administrative Hearing System (MAHS) will deny the request for an administrative hearing made by the representative if you do not provide proof of authorization. The authorized hearing representative needs to be authorized before they can make the request.

See "Resources" on page 37 for details on how to request for a hearing.



Apply without discrimination

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, audiotope, 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, S.W. 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.

Providing ethnicity and race is voluntary

Answering questions about race and ethnicity is voluntary. The information is collected to ensure that program benefits are distributed without regard to race, color or national origin. If you do not answer these questions, your eligibility or benefit levels will not be affected. If you choose not to answer these questions, your MDHHS specialist may choose an answer for you.

Apply as an immigrant

You may be eligible to receive benefits if you are a qualified immigrant, including:

- Lawful permanent residents or LPRs (people with green cards).
- Asylees and refugees.
- Parolees for more than 1 year.
- Cuban and Haitian entrants.
- Certain abused immigrants, their children, and/or their parents.
- Victims of trafficking.
- Veterans and active military, and their spouses and children.

Receiving food or emergency assistance will not affect your immigration status. If you are here illegally, it may affect your ability to stay in the United States.

Individuals who are not applying for assistance and adults applying for CDC are not required to provide immigration papers.

Apply as a United States citizen or national

For some programs, people claiming United States citizenship must provide proof of citizenship and identity. Acceptable proof of citizenship includes, but is not limited to, a United States passport, a certificate of naturalization, or a United States public birth record showing birth in the United States or United States territories. People receiving SSI, Social Security, Medicare, or adoption assistance, foster children and newborn “safe delivery” babies are not required to provide proof of United States citizenship.

Receive services for domestic violence

We may be able to waive some program requirements (such as working, looking for a job, pursuing child support or going to school) if participating would 1) put you or a family member in danger of physical or emotional harm 2) subject you to sexual abuse, or 3) otherwise be unfair to you. If any of these things apply to you or your family member, tell your MDHHS worker now. Also, see “Resources” on page 37 for details on how to access domestic violence services.

Receive help if you have a disability

You do not have to tell us about disabilities, but some help is only available to persons with disabilities. If you or someone in your household has a disability, we can make exceptions or give you special help. If you are denied special help or an exception you need because of a disability, and you think the denial was wrong, you may file a complaint of discrimination. If you do not tell us about a disability now, you can tell us about it later.

[Contact your MDHHS specialist if you need help.](#)

Register to vote

If you select ‘Yes’ or do not respond on your application, a voter registration application will be sent to you. If you select ‘No’, an application will not be sent to you. Applying or declining to register to vote will not affect the amount of assistance you will be provided by this department. 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 voter registration application in private. If you believe someone has interfered with your right to 1) register to vote 2) decline to register to vote 3) privacy in deciding whether to register or in applying to register to vote or 4) choose your own political party or other political preference, you may file a complaint with: Secretary of State, PO Box 20126, Lansing, MI 48901-0726.

Resources

Here are resources that can help you take action.

Find your local office

- Go online www.michigan.gov/contactmdhhs

Get help with your application

Your local MDHHS office will provide help with reading, writing, hearing, etc. or finding an interpreter during the application process. To get help:

- Call your local office to notify them that you will require assistance.
- If you are refused help, call the specialized action center: 855-275-6424.

You may also bring your own interpreter.

Report a change

You can report changes by 1) calling your MDHHS specialist (their name and number is listed on any correspondence you've received from MDHHS) 2) reporting online through MI Bridges 3) submitting a written statement or DHS-2240, Change Report form to your local office.

Ways to request the DHS-2240 form:

In person: Visit your local office and request form DHS-2240 or;

Print from home: Download form DHS-2240 online

- Complete and sign form.
- Include your name and case number when sending any document.
- Mail completed form to your local office.

If you file for bankruptcy, you can send a copy of the official bankruptcy notice to: MDHHS, Legal Services, PO Box 30195, Lansing, MI 48909.

Report fraud

Go to www.michigan.gov/welfarefraud or call 800-222-8558 to report suspected welfare fraud.



Request a hearing

Ways to request a hearing include:

By phone (FAP only): Call your specialist (their name and number are listed on any correspondence you've received from MDHHS) and request a hearing;
or

In person: Visit your local office and ask for a DHS-18, Request for Hearing form; **or**

By mail: Download form DHS-18 online

- Print, complete and sign form.
- Include your name, address, and case number.
- Attach a copy of the notice you received from MDHHS, if possible.
- Mail the signed and dated form to your local office, addressed to the hearings coordinator.
- Keep a copy of the request and any other document you attach for yourself.

Once a hearing is requested, you will receive a hearing date notice by mail.

File a general complaint

- Call the specialized action center: 855-275-6424; **or**
- Write your complaint and mail it to:
Michigan Department of Health and Human Services,
Specialized Action Center, PO Box 30037 Lansing, MI 48909.

Information on domestic violence

You are authorized to receive domestic violence comprehensive services.

- Find information online: www.michigan.gov/domesticviolence.
- Call the Domestic Violence Helpline: 800-799-7233.
- Read DHS-Pub-859, Is Someone Hurting You or Your Children? – online at www.michigan.gov/domesticviolence.

Receive help with welfare debt

Call Welfare Debt Collection toll-free at 800-419-3328 if you 1) have a debt with MDHHS pertaining to FAP, Cash Assistance or CDC recoupment 2) need direction on where to send your repayment 3) are inquiring on debt balance 4) need reissuance of a receipt for prior repayment 5) are considering disputing any pending collection action underway for the programs above, or 6) are looking for clarification or guidance about a collection notice from MDHHS involving these programs.

Receive Bridge Card help

Cash and/or FAP benefits are accessed by using a debit card. This debit card is called the Bridge Card or Electronic Benefit Transfer (EBT) card.

Call EBT Customer Service toll-free at 888-678-8914 to 1) report a lost, stolen or damaged card 2) request a replacement card 3) establish/change your personal ID number (PIN), or 4) find your balance. Customer service is available 24 hours a day, 7 days a week (Spanish and Arabic service is available). If you are hearing or speech-impaired, call the Michigan Relay Center at 800-649-3777.

After your first replacement card, your benefits may be reduced to cover the cost of replacing any additional cards.

[The same replacement card policy applies if you have someone who has access to your cash benefits \(protective payee\), or \(for FAP\) someone whom you approved to purchase food for your household \(authorized representative\).](#)

Contact other programs

If you have questions about any of the following programs, call:

- MICHild MDHHS: 888-988-6300.
- Medicare: 888-633-4227.
- State SSI Supplements: 855-275-6424.
- Energy Assistance: 855-275-6424.
- Community Resources and Referrals: 2-1-1.

Privacy Details

Information MDHHS will get from others

- **Social Security Administration information (all programs)** - You agree the Social Security Administration may give MDHHS all information needed to determine your eligibility.
- **Quality Control (QC) and/or Office of Inspector General (OIG) investigations** - MDHHS might choose your case for a quality control review or a complete investigation. If your case is chosen, MDHHS will contact you, other people, employers and/or agencies for proof of the information provided on your assistance application.
- **Law enforcement check (FAP, FIP, SER)** - MDHHS may give or receive information from law enforcement officials for the purpose of arresting persons fleeing to avoid the law.
- **Child care billing information (CDC)** - Information submitted by your child care provider will be used in determining payment amounts.
- **Computer cross-checking (all programs)** - MDHHS will check with federal, state and private agencies to make sure the information you provide on the assistance application is correct. If the information does not match, we may ask you to send us proof. Verification of the information you provide may affect your household's eligibility and level of benefits. MDHHS may check wages, income, assets, unemployment benefits, income tax refunds, Social Security benefits and numbers, child support, immigration status, etc.
- **Other states** - MDHHS will check records from other states. You may be denied benefits in Michigan if you or other household members were disqualified in another state.
- **Healthcare coverage** - You can consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). You will receive notice when this occurs, be able to make changes, and may opt out at any time. If you give any information that does not match, MDHHS may ask you to send us proof to find out what is correct. You may be asked for permission to contact employers, banks or other people.

Information MDHHS will give to others

- **Eligibility information (FAP)** - MDHHS sends food assistance program (FAP) eligibility information to schools. This information allows your child(ren) to receive free or reduced-cost meals.
- **CDC** - Notice will be sent to your child care provider when your CDC has been approved and authorized, changes occur that impact your CDC eligibility or your CDC eligibility has ended.
- **Undocumented aliens** - MDHHS may send information about certain undocumented aliens to the Department of Homeland Security.
- **Survey information** - You may be contacted for survey information to help evaluate MDHHS' quality of programs and customer service.

Penalties

These penalty policies apply to FAP, FIP, SDA and CDC.

Intentional Program Violation (IPV) is when you make a false or misleading statement, hide, misrepresent or withhold facts on purpose to receive or continue to receive extra benefits. If we think you committed fraud/IPV, we may hold an administrative hearing, bring criminal charges, or ask you to voluntarily sign a disqualification agreement.

FAP trafficking

You may also be guilty of fraud/IPV if you trade, attempt to trade or sell your FAP benefits or Bridge Card online or in person. You may not use or attempt to use FAP benefits or Bridge Cards that belong to another household for your household. You may not use FAP benefits or Bridge Cards to purchase or attempt to purchase anything other than food, seeds and plants to grow your own food for your household.

If it is proven in court that you are guilty of fraud:

- You are subject to criminal penalties (for example, fines up to \$250,000, jail/prison time up to 20 years, or both). You may be charged under other federal laws and a court may prevent you from receiving benefits for an additional 18 months; **and**
- You must repay any extra benefits you received because of the fraud/IPV; **and**
- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table on next page.

If it is proven in an administrative hearing you are guilty of IPV or you voluntarily sign a disqualification:

- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table on next page; **and**
- You will have to repay the extra benefits you received because of the fraud/IPV.

[These policies apply to other household members and authorized representatives as well. See “Resources” on page 36 for details on how to report suspected welfare fraud.](#)

Penalties (Continued)

<p>If you do any of the following:</p> <ul style="list-style-type: none"> • Make a false or misleading statement. • Hide, misrepresent or withhold facts to receive or continue to receive benefits. • Trade, attempt to trade or sell less than \$500 in FAP benefits or Bridge Cards online or in person. • Use or attempt to use FAP benefits to buy ineligible items such as alcoholic drinks or tobacco. • Purchase beverages with FAP benefits then immediately empty the contents and return container for the cash. • Use or attempt to use FAP benefits or Bridge Cards that belong to someone else for your household. 	<p>You will lose FIP/SDA and/or FAP benefits for:</p> <ul style="list-style-type: none"> • 1 year for the first violation • 2 years for the second violation • Life for the third violation
<p>If you are:</p> <ul style="list-style-type: none"> • Found by a court or an administrative hearing to have lied about your identity or where you live to receive benefits on two or more cases at the same time. 	<p>You will lose FAP benefits for:</p> <ul style="list-style-type: none"> • 10 years
<p>If you are:</p> <ul style="list-style-type: none"> • Convicted in court of lying about your identity or where you live to receive benefits in two or more cases at the same time. Benefits include programs funded under Title IV-A of the Security Act, Medicaid and Supplemental Security Income. 	<p>You will lose FIP benefits for:</p> <ul style="list-style-type: none"> • 10 years
<p>If any member of the household is found guilty in court of:</p> <ul style="list-style-type: none"> • Trading FAP benefits for drugs. 	<p>You will lose FAP benefits for:</p> <ul style="list-style-type: none"> • 2 years for the first offense • Life for the second offense
<p>If any member of the household is found guilty in court of:</p> <ul style="list-style-type: none"> • Trading or attempting to trade FAP benefits for firearms, ammunition or explosives. • Trading, buying, or selling or attempting to trade, buy, or sell FAP benefits of \$500 or more for anything other than food online or in person. • Paying or attempting to pay for food purchased on credit with FAP. 	<p>You will lose FAP benefits for:</p> <ul style="list-style-type: none"> • Life



CDC Penalties

Violation of program rules may result in a disqualification of 6 months, 12 months or a lifetime.



Quick Look at Submitting Proof

After you submit your application, your MDHHS specialist will send you a list of any documents you need to provide based on your specific case. These are examples of the types of proof documents you may be asked to provide.

Household

- Identification: driver's license, state ID or passport.
- Your Social Security Card and numbers for everyone in the household who is applying.
- Proof of alien status (green card or resident alien card).

Assets

- Account statements (checking, savings, 401ks, etc).
- Deeds for any property you own (houses, buildings, land/lot, other property).

Income

- Pay stubs.
- Receipt for unemployment compensation benefits (UCB).
- Award letters (for SSI, RSDI, worker's compensation, etc).

Expenses

- Receipts for child care, adult disabled care or elderly care.
- Medical receipts from recurring monthly expenses (like dialysis, monthly medication etc.) or bills from one-time expenses.
- Proof of rent or mortgage receipt.

When you submit documents provide copies – **we are not able to return original documents**. Copies can be made free of charge at your local MDHHS office.

[If you need help getting proof, ask your MDHHS specialist.](#)



Assistance Application

Submit this form by mail, fax, or bring it into a local MDHHS office

Find your nearest location at
www.michigan.gov/dhs-countyoffices
or call 855-ASK-MICH

Apply online:
www.michigan.gov/mibridges

Welcome!

- **Fill out the Assistance Application**
Answer questions about you and your household.

Fill out Program Details:



Healthcare Coverage

← Refer to the Information
Booklet for details on
each program



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**
It will be sent to your local MDHHS office for review and follow-up.
You may need to interview with a MDHHS Specialist.

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, háganos 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.

If you are refused help, call 855-275-6424.

Michigan Department of Health and Human Services

MDHHS-1171 (1-18)

Case #:

ID#:

Applicant Registration

☐ Homeless
Legal Name (First, Middle, Last)

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)

/ / - -
Date of Birth Social Security Number

() - () - @
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.
- ☐ I am a migrant or seasonal farmworker whose income has stopped 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.

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, get official information about this application, and act for me on all future matters with this agency.

Signature of Applicant Signature of Representative Date

If you are unable to finish the entire application today, you may complete this page and return it to MDHHS. Benefits begin from the date the office receives your application

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

← We need a Social Security number (SSN) for people who are requesting assistance and have an SSN or can get one. See Info Booklet (Pg 30) for more details

Household Members

2

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).

SSN and U.S. Citizen/National are optional for people who are not requesting assistance. See Info Booklet (Pg 30) for more details

Ethnicity/Race is optional and will not affect eligibility or benefits. See Info Booklet (Pg 34) for more details

	Relationship to you	Full Legal Name	Sex	Date of Birth	Social Security #	U.S. Citizen/National	Married	In the Home?
1	SELF		M F	/ /	- -	Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
2			M F	/ /	- -	Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
3			M F	/ /	- -	Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
4			M F	/ /	- -	Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
5			M F	/ /	- -	Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	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? ☐ 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 For Healthcare, only required for applicants

Do any children (under age 20) have a parent who is living outside the home?

☐ If yes, who? ☐ No

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 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?

☐ If yes, who? ☐ No

☐ Foster Child ☐ Foster Parent ☐ Adopted Child ☐ Non-parent Caregiver

Is anyone in your household currently a migrant farmworker, seasonal farmworker, refugee/asylee, victim of domestic violence, or victim of trafficking?

☐ If yes, who? ☐ No

☐ Migrant Farmworker ☐ Seasonal Farmworker ☐ Refugee/Asylee

☐ Victim of Domestic Violence ☐ Victim of Trafficking

If not a US citizen/national, does anyone have qualified immigration status?

☐ If yes, list below.

See Info Booklet (Pg 34) 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

This page is not required for
Childcare (CDC)

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

Healthcare-only applicants
should skip this page (unless
disabled or in need of long-term
care services)

Please include jointly owned
accounts and/or assets

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, explain. ☐ No

← In the last 90 days
for FAP and SER

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)

Is anyone in your household employed?

☐

If yes, list below.

☐

No

← Include anyone who worked in the last 30 days or expects to work next month

Who?	Employer Name	Avg Hrs/Wk	Wages/Tips (Before Tax)								work next m
			\$	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

☐

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/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
Childcare (CDC)

Dependent Care

For all expenses, only
include the amount you are
responsible to pay

Does anyone in your household pay for dependent care expenses? ☐ If yes, list below. ☐ No

☐ 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

Not required for Healthcare
(unless disabled or in need of
longterm care services)

☐ Health Insurance ☐ Prescriptions ☐ In-Home Care ☐ Hospital Bills
☐ Co-Pays ☐ Dental ☐ Transportation for Care ☐ Other

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

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? ☐ No

Has anyone ever been convicted for receiving cash or food assistance from two or more states for the same time period?

☐ If yes, who? ☐ No

Has anyone ever been convicted of a drug-related felony that occurred after August 22, 1996?

☐ If yes, who?
☐ Convicted more than once? Y | N

Voter Registration

Would you like help registering to vote at your current address?

← See Info Booklet (Pg 35) for more details

- ☐ Yes, send me a voter registration application.
- ☐ No thanks, I am already registered/do not need a voter registration application.

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, get information, and act for you on all future matters with MDHHS. This information can also be collected later in the process

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

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

() - @

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? ☐ No
(This should be someone you trust)

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 have received, reviewed, and agree to the information provided in the Information Booklet.

← By signing this application you are agreeing to these responsibilities

Please refer to your Information Booklet to read 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 (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

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, get official information about this application, and act for me on all future matters with this agency. If I am signing as an Authorized Representative for Healthcare coverage, 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



Notes



Use this page to add any additional information/notes



Healthcare Coverage



Please fill out the following details
along with the Assistance Application
if seeking Healthcare Assistance

Additional Group Details

Is anyone the primary caretaker for a child
(under age of 19) in the home?

<input type="checkbox"/>	If yes, who?	Caretaker	<input type="checkbox"/>	No
<input type="checkbox"/>		Child		

Does anyone live in a medical facility or
nursing home?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

Was anyone in foster care when they turned 18?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

← Only required for applicants

Is anyone applying for health insurance currently
incarcerated (detained or jailed)?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

American Indian or Alaska Native

AI/AN family members may not have
← to pay cost sharing and may get special
monthly enrollment periods

Are you or is anyone in your family American Indian or
Alaska Native?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

If yes, are they a member of a federally
recognized tribe?

<input type="checkbox"/>	If yes,	Tribe	<input type="checkbox"/>	No
--------------------------	---------	-------	--------------------------	----

Has anyone ever received a service or referral from
the Indian Health Service, a tribal health program,
or urban Indian health program?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

If no, is anyone eligible to get these services?

<input type="checkbox"/>	If yes, who?		<input type="checkbox"/>	No
--------------------------	--------------	--	--------------------------	----

Flint Water System

Did anyone in your home consume water from the Flint Water System and live,
work, or receive childcare or education at an address that was served by the
Flint Water System from April 2014 through present day?

<input type="checkbox"/>	If yes, list below.	<input type="checkbox"/>	No
--------------------------	---------------------	--------------------------	----

← For individuals under age 21 or pregnant women. By checking "yes" you are requesting Healthcare

Names

Address Served by Flint Water (Street, City, ZIP Code)

Dates

		MO/YR - MO/YR
--	--	---------------

☐ Home ☐ Work ☐ School ☐ Childcare Facility

--	--	--

☐ Home ☐ Work ☐ School ☐ Childcare Facility

Michigan Department of Health and Human Services

Your Name



Healthcare Coverage

Please fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Tax Filers

Does anyone applying plan to file a federal tax return next year? ☐ If yes, who? ☐ No

← You do not need to file a tax return to receive Healthcare

Name of Primary Tax Filer

Are they filing jointly with a spouse? ☐ If yes, who? ☐ Name of Spouse ☐ No

Are they claiming dependents? ☐ If yes, who? ☐ Name of Dependent(s) ☐ No

Are they filing jointly with a spouse? ☐ If yes, who? ☐ No

Are they claiming dependents? ☐ If yes, who? ☐ No

Dependents

Will anyone applying be claimed as a dependent on someone else's tax return? ☐ If yes, list below. ☐ No

Dependent	Tax Filer	Relationship to Tax Filer
Name	Name	

Yearly Income

Does anyone's income change from month to month? ☐ If yes, list below. ☐ No

Who?	Total Estimated Income This Year	Total Estimated Income Next Year
Name		

← If you think it will be different

Healthcare Coverage



Please fill out the following details
along with the Assistance Application
if seeking Healthcare Assistance

Health Coverage Info

Does anyone need help paying for medical bills
from the past 3 months?

☐

If yes, who?

Name(s)

☐

No

Which months?

JAN

FEB

MAR

APR

MAY

JUN

JUL

AUG

SEP

OCT

NOV

DEC

Did anyone have insurance through a job and lose it in the last 3 months?

☐

If yes, list below.

☐

No

Who lost coverage?

End Date

Reason Insurance Ended

Name	MM / YYYY	

Is anyone currently enrolled in health coverage
(even if not applying)?

☐

If yes, list below.

☐

No

← Including Medicaid, CHIP/MiChild,
Medicare,
VA Healthcare Programs,
Peace Corps,
Employer Insurance, TRICARE
(unless you have direct care or
Line of Duty), and Other

Type + Name of Coverage

Person Covered

Policy #

Name		

If Medicare, do you want help paying Medicare premiums? Y | N

If employer insurance: Is this COBRA coverage? Y | N

Is this a retiree health plan? Y | N

If other, is this a limited benefit plan (such as a school accident policy)? Y | N

To make it easier to determine your Healthcare
eligibility in future years, do you agree to the use of
IRS data for automatic renewals?

☐

Yes

☐

No

← This allows the Marketplace and the State of Michigan
to use income data (including information from tax
returns). See Info Booklet (Pg 8) for more details

If yes, for how many years?

5

4

3

2

1

Michigan Department of Health and Human Services

Your Name

Healthcare Coverage



Health Coverage from Jobs

Complete this page if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

If you need assistance, take a copy of this page to your employer and have them help you fill it out

Information on this page won't impact your application. It will be passed on to the federal government to determine your eligibility for APTC (Advanced Premium Tax Credits)

Is anyone in the household offered health insurance from a job?
This includes coverage from someone else's job, such as a parent or a spouse

☐ If yes, list below.

☐ If no, skip this page.

<input type="text" value="Name"/>	<input type="text" value="- -"/>	
Employee	Employee Social Security #	
<input type="text" value="Name"/>	<input type="text" value="Employer Identification # (EIN)"/>	<input type="text" value="Address of Employer"/>
Employer		
<input type="text" value="Name"/>	<input type="text" value="() -"/>	<input type="text" value="@"/>
Employer Contact	Phone # of Employer Contact	Email of Employer Contact
<small>(This should be the person or department who manages employee benefits)</small>		

Can the employee get coverage now or sometime in the next 3 months? ☐ If yes, when? ☐ No

List everyone who is eligible for coverage from this job

Does the employer offer a health plan that pays at least 60% of the total costs of benefits (the minimum value standard for health plans)?

☐ Yes

☐ No

If yes, how much would the employee have to pay for the lowest cost plan that meets the minimum value standard?

per

Don't include family plans. If the employer offers wellness programs, enter the premium that the employee would pay if they got the maximum discount for a tobacco cessation program

Will the employer make any changes for the new plan year (if you know)?

☐ If yes, list below.

☐ No

☐ Employer won't offer health coverage

Date of change

☐ The premium amount will change for the lowest cost plan that meets the minimum value standard

Date of change

Employee would pay this premium

per

Michigan Department of Health and Human Services

Your Name

Food Assistance Program (FAP)



Please fill out the following details
along with the Assistance Application
if seeking Food Assistance

Household Details

Does anyone buy and make food separately from the rest of the household?

☐ If yes, who? ☐ No

Is anyone living in a facility or special living arrangement (now or within the past 3 months)?

☐ If yes, who? ☐ No

Is anyone in your household going to an alcohol or drug treatment program?

☐ If yes, who? ☐ No

Does anyone in your household receive tribal food distribution benefits?

☐ If yes, who? ☐ No

Has anyone received Food Assistance from another state in the last 30 days?

☐ If yes, who? ☐ No
☐ State

Housing Expenses

Does anyone in your household pay for housing expenses?

☐ If yes, list below. ☐ No

← Only list the amount you pay, not Housing Choice Voucher (Section 8), HUD, MSHDA, etc.

☐ Rent ☐ Land Contract ☐ Homeowner's Insurance ☐ Other
☐ Mortgage ☐ Mobile Home Lot Rent ☐ Property Tax

Only list Insurance/Property Tax if not included in mortgage

Who pays?	Type of Expense	Amount	How Often Paid
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

Utilities

Does anyone in your household pay for utilities (not included in rent)?

☐ If yes, check below. ☐ No

☐ Heat ☐ Electricity ☐ Trash Pickup ☐ Cooking Fuel
☐ Air Conditioning ☐ Water/Sewer ☐ Phone

← Heat types include gas, electric heating, propane, wood, etc.

Electricity does not include heat or air conditioning

If utilities are included in your rent, does anyone in your household pay an extra fee for air conditioning?

Y | N

Has anyone applying for FAP received more than \$20 in State Emergency Relief (SER) energy payments or Michigan Energy Assistance Program (MEAP) payments in the last 12 months?

Y | N

Has anyone applying for FAP received more than \$20 in the Home Heating Credit (HHC) in the last 12 months?

Y | N

Michigan Department of Health and Human Services

Your Name

Cash Assistance



Please fill out the following details
along with the Assistance Application
if seeking Cash Assistance

Is anyone in the household...

Living in a facility or special living arrangement now
or within the past 3 months?

☐

If yes, who?

Name(s)

☐

No

Going to an alcohol or drug treatment program?

☐

If yes, who?

☐

No

Attending special education classes?

☐

If yes, who?

☐

No

Receiving Michigan Rehabilitation Services?

☐

If yes, who?

☐

No

Receiving medical assistance based on disability or
blindness?

☐

If yes, who?

☐

No

Currently applying (or planning to apply) for disability
benefits with the Social Security Administration
(SSA)?

☐

If yes, who?

☐

No

Have or expect to have medical coverage (including
accident insurance, worker's compensation, health
savings, health/hospital insurance or other)?

☐

If yes, who?

☐

No

Fleeing from felony prosecution, an outstanding
felony warrant or jail?

☐

If yes, who?

☐

No

In violation of probation or parole?

☐

If yes, who?

☐

No

Received Cash Assistance from another state
since August 1996?

☐

If yes, who?

☐

No

State

For children in the household

Are there children under 6 years of age who are not
up-to-date on their immunizations (shots)?

☐

If yes, who?

☐

No

Are any children (ages 6-18) in school now?

☐

If yes, list below.

☐

No

Name(s)

Michigan Department of Health and Human Services

Your Name

Child Development + Care (CDC)



Please fill out the following details
along with the Assistance Application
if seeking Child Care Assistance

Do you currently live in temporary or emergency housing? Y | N

You need child care so that you can participate in (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Work | <input type="checkbox"/> Activity required by MDHHS Child Protective Services |
| <input type="checkbox"/> High School or GED Completion/Education | <input type="checkbox"/> Treatment for Health or Social Condition (explain): |
| <input type="checkbox"/> Training/Employment Preparation | |
| <input type="checkbox"/> PATH program or other approved activity | |

If you are in school, do you need study time? Y | N

How many hours of child care do you need every two weeks? #

Is either parent serving active duty in the U.S. Military? ☐ If yes, who? ☐ No

Is either parent a member of the National Guard or Military Reserve Unit? ☐ If yes, who? ☐ No

Does the household have total assets that exceed one million dollars? Y | N

← This is an actual question;
it is required on a federal level

Children (Age 18 and Under) in Household

Child Legal Name (First, Middle, Last)	Parent Legal Names (First, Middle, Last)	Living at Home with the Child?	Child up to Date on Immunizations (Shots)?
<input type="text"/>	Mother	Y N	Y N
	Father	Y N	
<input type="text"/>	<input type="text"/>	Y N	Y N
	<input type="text"/>	Y N	
<input type="text"/>	<input type="text"/>	Y N	Y N
	<input type="text"/>	Y N	

Need more room to write? Go to notes on last page. ☐ Yes, I've added more notes.

Michigan Department of Health and Human Services

Your Name

State Emergency Relief (SER)



For energy related emergencies, the SER crisis season runs from November 1 - May 31. Requests for those services will be denied June 1 - October 31

Emergency Need

What services are you requesting? Check below and list the amount needed to resolve the emergency.

<input type="checkbox"/> Heat (see details below)	<input type="checkbox"/> Property Taxes \$ _____	<input type="checkbox"/> Burial / Cremation \$ _____
<input type="checkbox"/> Electricity (see details below)	<input type="checkbox"/> Homeowner's Insurance \$ _____	<input type="checkbox"/> Migrant Hospitalization \$ _____
<input type="checkbox"/> Water/Sewer \$ _____	<input type="checkbox"/> Mortgage \$ _____	<input type="checkbox"/> Security Deposit \$ _____
<input type="checkbox"/> Cooking Gas \$ _____	<input type="checkbox"/> Home Repairs \$ _____	<input type="checkbox"/> Moving Expenses \$ _____
<input type="checkbox"/> Eviction/Relocation \$ _____	<input type="checkbox"/> Furnace Repair \$ _____	

Heat Request Details

How do you heat your home?

<input type="checkbox"/> Natural Gas	<input type="checkbox"/> Propane	<input type="checkbox"/> Wood	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Electricity	<input type="checkbox"/> Coal	<input type="checkbox"/> Fuel Oil	

Describe your current situation:

<input type="checkbox"/> My heat has been turned off/I have run out of my household's heating fuel source	
<input type="checkbox"/> I have received a past due or shut off notice/I am at risk of running out of my household's heating fuel source	
Date of shut off _____ / _____ / _____	Current balance (If prepaid account) \$ _____ % remaining in tank _____ % ← To qualify, must be less than 25% at time of delivery

Electricity Request Details

Describe your current situation:

<input type="checkbox"/> My electricity has been turned off	
<input type="checkbox"/> I have received a past due or shut off notice	
Date of shut off _____ / _____ / _____	Current balance (If prepaid account) \$ _____

Michigan Department of Health and Human Services

Your Name

State Emergency Relief (SER)



Current Housing Expenses

Do you pay for any housing expenses? ☐ If yes, list below. ☐ No

	Name of Service Provider	Name on Bill/Account	Account #	Is This a Shared Meter?	Is There Theft or Illegal Use?
<input type="checkbox"/> Heat				Y N	Y N
<input type="checkbox"/> Electricity				Y N	Y N
<input type="checkbox"/> Water/Sewer				Y N	Y N
<input type="checkbox"/> Cooking Fuel				Y N	Y N
<input type="checkbox"/> Rent					
<input type="checkbox"/> Mortgage					
<input type="checkbox"/> Property Taxes					
<input type="checkbox"/> Home Insurance					

Household Information

Tell us about your expenses, income, and the people who have lived with you over the past 6 months.

	1 Month Ago	2 Months Ago	3 Months Ago	4 Months Ago	5 Months Ago	6 Months Ago
Month						
# of people in Home						
Total Monthly Income (Before Tax)	\$	\$	\$	\$	\$	\$
Rent / Mortgage	\$	\$	\$	\$	\$	\$
Heat	\$	\$	\$	\$	\$	\$
Electricity	\$	\$	\$	\$	\$	\$
Water / Sewer / Cooking Gas	\$	\$	\$	\$	\$	\$

Is anyone in the household in violation of probation or parole?

☐ If yes, who? ☐ No

Michigan Department of Health and Human Services

Your Name

State Emergency Relief (SER)



If this application is for burial services, it must be received by MDHHS no later than 10 business days after the burial, cremation, or donation takes place

Burial Service Request

If you are applying for burial services, please complete this page. Be sure to answer questions on the Assistance Application for the deceased, their spouse, and their parents (if deceased is a minor child).

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
Name of Deceased (First, Middle Last)	Date of Death	Your Legal Relationship with the Deceased
<input type="text"/>	<input type="text"/>	<input type="text"/> (<input type="text"/>) - <input type="text"/>
Name of Funeral Home	Address of Funeral Home	Phone of Funeral Home
Is this a cremation? Y N	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Place of Burial/Crematory	Date of Burial/Cremation

Is payment to the cemetery/crematory separate from the payment to the funeral home? Y | N

Did you sign a statement of goods and services with the funeral home? Y | N

Is there a memorial service? Y | N

Is the deceased a veteran? Y | N

Did the deceased own his or her home?	<input type="checkbox"/>	If yes, address?	<input type="text"/>	<input type="checkbox"/>	No
Is there a co-owner for this home?	<input type="checkbox"/>	If yes, who?	<input type="text"/>	<input type="checkbox"/>	No

Cost of burial/cremation \$

Is there a contribution from family/friends? ☐ If yes, how much? \$ No ☐

Are there any death benefits that you have applied for or expect to receive? ☐ If yes, list below. ☐ No

<input type="checkbox"/> Accident / Automobile Insurance	<input type="checkbox"/> Pre-paid Funeral Agreement	<input type="checkbox"/> Social Security Death Benefits
<input type="checkbox"/> Veteran's Death Benefit	<input type="checkbox"/> Labor Union Benefits	<input type="checkbox"/> A Community Assistance Fund / Fraternal Organizations
<input type="checkbox"/> Life Insurance	<input type="checkbox"/> Other (list below)	

Type of Death Benefits	Amount
<input type="text"/>	\$ <input type="text"/>

Michigan Department of Health and Human Services

Your Name