



STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION

Formerly Known As The Food Stamp Program

THIS APPLICATION IS FOR SNAP PROGRAM FOOD ASSISTANCE ONLY.

FOR INFORMATION ON MEDICAL, CASH, AND/OR CHILDCARE ASSISTANCE, CONTACT A RI DHS FAMILY CENTER.

WOONSOCKET REGIONAL FAMILY CENTER

450 Clinton Street
Woonsocket, RI 02895
Telephone: (401) 235-6200
or 1-800-510-6988
Fax: (401) 235-6237

- Serves:
Burrillville
Cumberland
Foster
Glocester
Lincoln
North Providence
North Smithfield
Smithfield
Woonsocket

PROVIDENCE REGIONAL FAMILY CENTER

206 Elmwood Avenue
Providence, RI 02907
Telephone: (401) 415-8200
Fax: (401) 415-8349

- Serves:
Cranston
Johnston
Providence
Scituate

NEWPORT REGIONAL FAMILY CENTER

272 Valley Road
Middletown, RI 02842
Telephone: (401) 851-2100
or 1-800-675-9397
Fax: (401) 851-2105

- Serves:
Jamestown
Little Compton
Middletown
Newport
Portsmouth
Tiverton



PAWTUCKET REGIONAL FAMILY CENTER

249 Roosevelt Avenue
Pawtucket, RI 02860
Telephone: (401) 721-6600
or 1-800-984-8989
Fax: (401) 721-6659

- Serves:
Barrington
Bristol
Central Falls
East Providence
Pawtucket
Warren

WARWICK REGIONAL FAMILY CENTER

195 Buttonwoods Avenue
Warwick, RI 02886
Telephone: (401) 736-1400
or 1-800-282-7021
Fax: (401) 736-1443

- Serves:
Warwick
West Warwick

SOUTH COUNTY REGIONAL FAMILY CENTER (OLIVER STEDMAN CENTER)

4808 Tower Hill Road
Wakefield, RI 02879
Telephone: (401) 782-4300
or 1-800-862-0222
Fax: (401) 782-4316

- Serves:
Charlestown
Coventry
East Greenwich
Exeter
Hopkinton
Narragansett
New Shoreham
North Kingstown
Richmond
South Kingstown
West Greenwich
Westerly

AM I ELIGIBLE? HOW DO I APPLY? WHERE CAN I GET HELP APPLYING?

RI DHS SNAP Office locations are listed above.

Online at WWW.FOODSTAMPS.RI.GOV or WWW.DHS.RI.GOV

RI DHS Information Line 401-462-5300

SNAP Outreach Application Assistance 1-866-306-0270

STEPS TO FOLLOW

STEP 1- APPLY ONLINE OR COMPLETE, SIGN AND DATE THIS APPLICATION. Please sign each box with the heading, “Signature Required.” These signature boxes are located on page 2 of 4, page 4 of 14 and page 14 of 14. When filling out this application, you may use the “Worksheet” sections for additional space. If you need assistance, contact your local SNAP office or call the SNAP Outreach Application Assistance number listed on the front cover, or visit your local Community Action Agency listed on the back of the application.

If you and/or all your household members are elderly (age 60 or older), you only need to answer the questions marked with an “*” unless otherwise instructed by your DHS worker during your interview.

PLEASE DO NOT MARK THE AREAS TO THE RIGHT OF THE QUESTIONS (i.e. MEMB VER) OR ANY AREAS THAT MAY BE MARKED “For Agency Use Only”.

STEP 2- MAIL, FAX OR DROP OFF your application to a local SNAP office for timely processing. We must have a SIGNED application IN THE DHS OFFICE in order to date stamp and process your application. **You may file this application right away as long as we get the front and backside of the Part 1 - Application page number 1 of 14 with your name, address, telephone number and the signature of a responsible household member or authorized representative.**

STEP 3-AN INTERVIEW IS REQUIRED. To determine whether or not you are eligible, you must be interviewed. Information provided in the application for SNAP benefits is subject to verification by Federal, State and local officials to determine if such information is factual; if any information is incorrect, SNAP benefits may be denied; and the applicant may be subject to criminal prosecution for knowingly providing incorrect or false information. We are required to verify such information and to determine eligibility within thirty (30) days from the date your application is received, unless you are entitled to receive expedited benefits within seven (7) days (see next page). Benefits are provided from the date of application. The application filing date for pre-release applicants is the date of release from the institution.

Please refer to the inside back cover, SNAP Guidelines – Resource Sheet, for the SNAP Benefits Eligibility Guidelines.

FOR AGENCY USE ONLY: Person Clearance For Participation

Prior Record		Status	RL	Request Date	Social Security No.		
SNAP	<input type="checkbox"/> YES <input type="checkbox"/> NO						

DISPOSITION: _____ MEMB VER

APPLICATION RECERTIFICATION INTERVIEW DATE: _____

LEVEL OF EDUCATION: GED HS CERTIFICATE DEGREE OTHER

Comments: _____

Signature of Screener/Interviewer _____

Date _____

For Agency Use Only:
Date Stamp

Expedited YES NO

If you have a disability or condition that makes it hard for you to understand or answer questions on this application, we can help. For example, we can read the form with you and write your answers for you. We can make other accommodations, depending on what assistance you need. Please let us know.

***1. Do You Need an Interpreter?** Yes No If needed, interpreter services are provided free of charge.

***Please answer the following questions:**

- a. Do you speak English? Yes No If no, what is the primary language spoken? _____
- b. Does any adult member of the household speak English? Yes No
- c. Can you read and write in English? Yes No

***How Would You Like to Be Interviewed?** CHECK ONE OF THE BOXES: TELEPHONE INTERVIEW
(DHS will call you)(or)IN-OFFICE INTERVIEW IMPORTANT: If you do not check one of the boxes above, a Telephone Interview will be scheduled for you.

YOU MUST PROVIDE A PHONE NUMBER WHERE YOU CAN BE REACHED: _____
Daytime Evening

First Name _____ MI _____ Last Name _____ Maiden Name _____
Social Security # _____ - _____ - _____ Date of Birth _____ - _____ - _____
Marital Status: Single Married Divorced Other Sex: Male Female

Street Address _____ Apt. # _____ City/Town _____ State _____ Zip Code _____
Mailing Address (If Different) _____ Apt. # _____ City/Town _____ State _____ Zip Code _____

***2. Are You Eligible for Expedited Service?**

YOU MAY GET SNAP BENEFITS, IF ELIGIBLE, WITHIN 7 DAYS IF: your income, cash and money in the bank add up to less than your monthly housing expense; or your monthly income is less than \$150 and your money in the bank and liquid resources are less than \$100; or you are a migrant or seasonal farm worker.

- a. How much money do members of your household have in cash or money in the bank? \$ _____
- b. What is the total amount of income from any source (including unearned income such as Child Support, SSI, TDI, Unemployment, or SSDI, etc.) you expect your household to receive this month? \$ _____
- c. What is your current monthly rent/mortgage payment? \$ _____ Utilities? \$ _____
- d. Is anyone in your household a migrant or seasonal farm worker? Yes No

If you have children, you may qualify for other services. Please call or visit your local DHS office.

***3. My shelter arrangement is (Check one):**

- 01 Elderly/disabled housing 06 Own home/trailer 11 Non-traditional: lobby, street, automobile
 02 Drug/alcohol rehab center 07 Rent home/apt/trailer 12 Residential care and assisted living
 03 Disabled/blind group home 08 Living in another's home/apt. 13 Long-Term Care Facility
 04 Battered Women's shelter 09 No permanent address 99 Other (specify) _____
 05 Shelter 10 Halfway house

***4. Is anyone in the home hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony, attempted felony, or violating parole or probation?** YES NO

If yes, list name(s) of household members:

NAME: _____ DATE: _____ STATE: _____

***5. Have you, or anyone applying with you, ever received SNAP/Food Stamps, Cash Assistance (TANF) or Medical Assistance benefits from another State?** YES NO

If yes, list name of household member(s) _____ STATE: _____

START DATE _____ END DATE _____

***6. Have you, or anyone applying with you, ever been convicted of trading SNAP/Food Stamps benefits for guns, ammunitions, or explosives after September 22, 1996?** YES NO

If yes, list name of household member(s) _____

***7. Would you like to authorize someone other than yourself to apply on your behalf?** YES NO

If yes, provide name of authorized representative: _____

Daytime Phone #: _____ Evening Phone #: _____

****Signature Required****

By signing this application, I certify under penalty of perjury that I have read (or have had read to me) and understand the Notice of Rights, Responsibilities and Penalties, and that my answers are correct, and complete to the best of my knowledge and belief. I know that under State of RI General Laws, Section 40-6-15, a maximum fine of \$1,000 or imprisonment for up to 5 years, or both may be imposed for a person who obtains, attempts to obtain, or aids or abets any person to obtain public assistance to which s/he is not entitled or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Person Helping You Complete This Form	Date
Signature of Guardian, Conservator or Holder of Power of Attorney	Date	Signature of Agency Representative	Date

*** Submitting JUST the front and backside of this page with Name, Address, Telephone Number, and Signature allows us to date stamp and initiate this application only. You must be interviewed to determine eligibility in both expedited and regular processed cases. Expedited benefits are active for up to 2 months only. To determine ongoing benefit eligibility, you must sign and complete both PART I & PART II of this application. Bring or send in the required documentation to determine ongoing benefits. ***

WITHDRAWAL OF APPLICATION

*****FOR AGENCY USE ONLY*****

After participating in the screening interview, I do not wish to make an application at this time. I understand that I may apply again at any time. I understand that this application will be denied and a notice of denial will be sent to me. Please state your reason for withdrawing your application: _____

Applicant's Signature _____

Date _____

SNAP APPLICATION - PART II

*1. Do You Need Someone to Apply for You?

YES NO

You can choose an authorized representative to fill out your application, give information at your interview, and speak with your DHS worker about your case. If you wish to have an authorized representative, complete the following information on this person:

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____

MEMB VER

*2. Who Lives in Your Home? Include yourself as Member 1.

* Marital Status Codes: M - Married S - Separated D - Divorced W - Widow/Widower N - Never Married ** Race Codes: W - White I - American Indian/Alaskan Native
B - Black or African American N - Native Hawaiian/Pacific Islander A - Asian

Complete the following information for all people living in your home. Be sure to list everyone, even if they do not want assistance.				List the information on this side only if the person is requesting benefits. (Completion of the race section is voluntary, it will not affect eligibility or the level of benefits, and the reason for the information is to assure that program benefits are distributed without regard to race, color, or national origin.)					
Name	Relation To You (Spouse, Son, Daughter, Sibling, Friend etc.)	Applying for Benefits (Circle One)	Date of Birth	Social Security Number	Sex (Circle One)	Marital Status *	Race **	Hispanic or Latino (Circle One)	U.S. Citizen (Circle One)
Last Name: First and MI:	Self	Yes No		____/____/____	M F			Yes No	Yes No
Last Name: First and MI:		Yes No		____/____/____	M F			Yes No	Yes No
Last Name: First and MI:		Yes No		____/____/____	M F			Yes No	Yes No
Last Name: First and MI:		Yes No		____/____/____	M F			Yes No	Yes No
Last Name: First and MI:		Yes No		____/____/____	M F			Yes No	Yes No

Please use the worksheet enclosed to record any additional members and/or information for any question on this application. To ensure processing accuracy, write the corresponding question number and application page number on the worksheet provided on page 13.

3. If you live in a household with a minor child (under age 18), is there more YES NO than one adult parent or adult other than you in the household who shares parental control/rights of the child/children?

If you live in such a household, please designate an adult parent or adult who has parental control over the children as the head of the household here:

PARE
VER

NAME: _____

***4. If you or anyone applying for benefits is a non-citizen, please provide information about each applicant household member's current status in the U.S. by filling in the information below.**

NAME: _____ Country of Origin: _____

AL
VER

Alien Registration Number: _____ Immigration Number: _____

Date you entered the United States: _____ Name of Sponsor: _____

Sponsor's Address: _____

Alien Status: Refugee Permanent Resident Other Date of Entry: _____ LPR Legal Permanent Resident Status Date: _____

NAME: _____ Country of Origin: _____

Alien Registration Number: _____ Immigration Number: _____

Date you entered the United States: _____ Name of Sponsor: _____

Sponsor's Address: _____

Alien Status: Refugee Permanent Resident Other Date of Entry: _____ LPR Legal Permanent Resident Status Date: _____

SAV-1 VER

Signature Required

**** All Applicants Must Sign Here Regardless of Citizenship Status ****
CERTIFICATION OF CITIZENSHIP/ALIENAGE

I certify, under penalty of perjury, by signing my name below, that the information I have provided in question NUMBER 2 and question NUMBER 4 is correct and complete regarding EACH applicant's citizenship/alien status to the best of my knowledge and belief.

NAME: _____

SIGNATURE: _____ DATE: _____

Alien status of applicant household members may be subject to verification by the United States Citizen and Immigration Services (USCIS) through the submission of information from the application to USCIS, and the submitted information received from USCIS may affect the household's eligibility and level of benefits.

***5. Are you or any member of your household living in a group living arrangement such as the types listed below?** YES NO

If yes, complete the information below for each household member(s):

**GRO
VER**

(Homeless Shelter, Alcohol/Drug Treatment Center, Hospital, Assisted Living Facility, Dormitory, Correctional Institute, Group Home, Battered Women Shelter.)

Name of Household Member in Group Living Arrangement

Name of Facility

6. Are you or anyone in the household who is sixteen (16) or older in High School, College, Vocational School or a Job-Training Program? YES NO

If yes, complete the information below for each person:

SCHL VER
FORM-C1A

Name: _____ **Check One:** Full Time Half Time Less than Half Time

School or Training Program: _____ **Date of Completion:** _____

Name: _____ **Check One:** Full Time Half Time Less than Half Time

School or Training Program: _____ **Date of Completion:** _____

Name: _____ **Check One:** Full Time Half Time Less than Half Time

School or Training Program: _____ **Date of Completion:** _____

***7. Is there someone in your home who does not purchase and prepare meals with you?** YES NO

If yes, complete the information below for each person:

EATS

Name: _____ **Name:** _____

Name: _____ **Name:** _____

***8. Are you, your spouse, or anyone in the household mentally or physically ill, incapacitated, disabled or blind?** YES NO

If yes, complete the information below:

**DISA
VER**

Name: _____ **Medical problem (describe)** _____ **Caused by an accident?**
 YES NO

Has this person applied for SSI or Social Security Benefits (RSDI)? YES NO **Has this person applied for Veteran Benefits (VA)?**
 YES NO

Name: _____ **Medical problem (describe)** _____ **Caused by an accident?**
 YES NO

Has this person applied for SSI or Social Security Benefits (RSDI)? YES NO **Has this person applied for Veteran Benefits (VA)?**
 YES NO

9. Has anyone's job in your household ended in the last 60 days? YES NO
Is anyone currently on strike? YES NO

QUIT/STRK
VER

If yes, complete the information below for each person:

Name Reason for Leaving Employer Last Day Worked/
Date Strike Began Final Pay Date

***10. Does anyone in your household, including children, earn or expect to earn job income?** YES NO

JINC VER

If yes, list all job income below:

Name	Employer	This Month's Gross Income (Including Tips and Commission)	Hours Worked Per Week	Hourly Wage/ Salary	How Often Paid (Monthly, weekly, bi-weekly, etc.)	Date of Next Paycheck
Last First & MI		\$		\$		
Last First & MI		\$		\$		
Last First & MI		\$		\$		

Information available through the income and eligibility verification system (IEVS) will be requested, used and may be verified through collateral contact. When discrepancies are found, such information may affect the household's eligibility and level of benefits.

***11. Do you, your spouse, or anyone in the household receive income from rent?** YES NO

RINC
VER

If yes, complete the information below:

Property Owner's Name Total Rent Received / How Often Hours Worked per Month Maintaining Property Number of Units

\$ _____ Per _____

\$ _____ Per _____

Does the person(s) listed above live in the rental property? YES NO

Mortgage Principal \$ _____ Per _____ Taxes \$ _____ Per _____ Insurance \$ _____ Per _____

Mortgage Interest \$ _____ Per _____ Gas/Oil \$ _____ Per _____ Water \$ _____ Per _____

Insurance \$ _____ Per _____ Sewer \$ _____ Per _____ Repairs \$ _____ Per _____

Garbage \$ _____ Per _____ Electric \$ _____ Per _____ Other \$ _____ Per _____

***12. Do you or does anyone in the household receive payments for room or board/meals?**

YES NO

If yes, complete the information below:

RBIN VER

Name of Person Receiving Payment: _____ Amount Paid / How Often _____ Will This Income Be Received In The Following Months?
 _____ \$ _____ Per _____ YES NO

Name of Person Paying: _____

What Does This Payment Cover? Room Only _____ Room/ Board (1-2 Meals) _____ Room/ Board (3 Meals) or more per day _____
 1 - 2 Meals Only _____ 3 or more Meals Only _____ Foster Care (Room & 3 Meals or more per day) _____

***13. Do you, your spouse, or anyone in the household receive income from self-employment?**

YES NO

If yes, complete the information below for each household member who receives income from self-employment:

BUSI VER

Examples include, but are not limited to: lawn care, hair cutting, home repair, fishing, daycare, door-to-door sales, home party sales, or property rental.

NAME: _____ GROSS INCOME _____ PER: _____

AVERAGE NUMBER OF HOURS WORKED PER WEEK _____

NAME OF BUSINESS: _____ DATE BUSINESS BEGAN: _____

WILL THIS INCOME BE RECEIVED IN THE FOLLOWING MONTH? _____

PLEASE LIST ALL YOUR BUSINESS INCOME:

TYPE OF INCOME/WORK	AMT. OF INCOME	EXPENSES	FREQUENCY	
			Monthly	Yearly

NAME: _____ GROSS INCOME _____ PER: _____

EXPENSES: \$ _____ AVERAGE NUMBER OF HOURS WORKED PER WEEK _____

NAME OF BUSINESS: _____ DATE BUSINESS BEGAN: _____

WILL THIS INCOME BE RECEIVED IN THE FOLLOWING MONTH? _____

PLEASE LIST ALL YOUR BUSINESS INCOME:

TYPE OF INCOME/WORK	AMOUNT OF INCOME	FREQUENCY
	\$	
	\$	
	\$	
	\$	
	\$	

14. Do you or anyone in your household receive income from work study, a student grant, scholarship, educational loan, or VA educational benefits?

YES NO

If yes, complete the information below:

STIN
VER

NAME _____ TYPE OF LOAN/GRANT _____ PERIOD COVERED _____ TO _____ AMOUNT \$ _____

***15. Does anyone in your household, including children, receive or expect to receive income that is not from a job?**

YES NO

If yes, complete the information below.

UNEA
VER

Examples include, but are not limited to: Bank Account, Child Support, Alimony, Social Security (RSDI, SSI), Unemployment, TDI, Workers' Compensation, Veteran's Benefits, Retirement, Interest, Pensions, Annuities, Dividends, Prizes, Money from Family and Friends, Adoption Subsidy, Foster Care, Military Allotment, Inheritance, Lottery, Alien Sponsorship, Earned Income Tax Credit, gifts, etc.

NAME: _____ TYPE OF INCOME: _____ GROSS AMOUNT THIS MONTH: _____

NAME: _____ TYPE OF INCOME: _____ GROSS AMOUNT THIS MONTH: _____

NAME: _____ TYPE OF INCOME: _____ GROSS AMOUNT THIS MONTH: _____

NAME: _____ TYPE OF INCOME: _____ GROSS AMOUNT THIS MONTH: _____

NAME: _____ TYPE OF INCOME: _____ GROSS AMOUNT THIS MONTH: _____

Will this income continue next month? YES NO

**(If you report and provide proof of your expenses shown in questions 16 through 22, you will get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense)*

16. Does anyone in the household pay daycare costs for children, elderly or disabled adults due to work, training, looking for work or schooling?

YES NO

If yes, fill in the information below.

DCEX
VER

Name of Person Paying for Care

Reason (circle one)

1. _____ School / Work

2. _____ School / Work

Name(s) of Person Receiving Care	Type of Care (circle one)	Cost of Care/ How Often	Is Cost Subsidized? (i.e. State-Funded Child Care)	If Yes, Subsidy Amount
----------------------------------	---------------------------	-------------------------	--	------------------------

1. _____	Adult / Child	\$ _____ per _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
----------	---------------	--------------------	--	----------

2. _____	Adult / Child	\$ _____ per _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
----------	---------------	--------------------	--	----------

3. _____	Adult / Child	\$ _____ per _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
----------	---------------	--------------------	--	----------

4. _____	Adult / Child	\$ _____ per _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____
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17. Do you or anyone in your household pay court-ordered child support or alimony to another household?

YES NO

If yes, complete the information below:

SUPP VER

Who Pays _____	Amount Paid / How Often _____ per _____	Name of children for whom support is paid _____
Who Pays _____	Amount Paid / How Often _____ per _____	Name of children for whom support is paid _____

***18. Do you, or anyone in your household, pay all or a share of rent, mortgage payment, property taxes, insurance, lot/rent, home equity loan, condo fees or other costs for the home you live in?** YES NO

RENT/HOME VER

If yes, complete the information below:

Rent \$ _____ per _____ Included in Rent? Yes No Is the rent subsidized? (i.e. Section 8)? Yes No If yes, the amount of the subsidy is \$ _____ per _____

Heat Utilities Yes No

If renting, list Landlord's name _____ Landlord's Address _____

Landlord's Phone Number _____ Does anyone share the cost of the rent? Yes No

If yes, Name _____ Amount \$ _____ per _____

Mortgage _____ per _____ Interest \$ _____ per _____ Property Taxes \$ _____ per _____

Homeowner's Insurance \$ _____ per _____ Lot/Rent \$ _____ per _____ Other \$ _____ per _____

Mortgage holder and Address: _____

***19. Did you get a Low Income Home Energy Assistance Program (LIHEAP) Grant at your current address in the last twelve (12) months for heating assistance?** YES NO

UTIL VER

***20. Do you or anyone in your household pay for utilities?** YES NO

If yes, complete the information below:

UTIL VER

Name of Person Paying Utility	Utility	Amount Paid/How Often	Used to Heat/Cool
_____	Oil	\$ _____ per _____	Heat <input type="checkbox"/> Cool <input type="checkbox"/>
_____	Gas	\$ _____ per _____	Heat <input type="checkbox"/> Cool <input type="checkbox"/>
_____	Wood/Coal	\$ _____ per _____	Heat <input type="checkbox"/> Cool <input type="checkbox"/>
_____	Electric (or A/C)	\$ _____ per _____	Heat <input type="checkbox"/> Cool <input type="checkbox"/>
_____	Telephone	\$ _____ per _____	
_____	Water/Sewer	\$ _____ per _____	
_____	Trash Removal	\$ _____ per _____	
_____	Other	\$ _____ per _____	

***21. Do you or does anyone in the household pay for room and/or board/meals?** YES NO

If yes, complete the information below: RBEX
VER

Name _____ Amount Paid / How Often _____ What Does the Room/Board Cover?
 _____ \$ _____ Per _____ Room Only _____ Board (1-2 Meals) _____ Board (3 Meals) _____

Name _____ Amount Paid / How Often _____ What Does the Room/Board Cover?
 _____ \$ _____ Per _____ Room Only _____ Board (1-2 Meals) _____ Board (3 Meals) _____

***22. Does anyone in your household who is disabled or age 60 or older pay medical costs not covered by insurance?** YES NO

If yes, complete the information below: FMED
VER

Examples include, but are not limited to: Health Insurance Premiums, Medicare Premiums, Dental Care, Hearing Aids, Eyeglasses, Prescription Drugs, Transportation to Medical Appointments, Doctor and Hospital Bills

Name	Type of Medical Cost	Total Amount Per Month	Date Costs are Expected to End
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

***23. Have you or any member of your household been barred from participating in the Supplemental Nutrition Assistance/Food Stamp Program in another state?** YES NO

If Yes, under what name? _____ Where? _____ When? _____ Why? _____

***24. Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?** YES NO

If Yes, under what name? _____ Where? _____ When? _____

***25. Have you or any member of your household been convicted of buying or selling SNAP benefits over \$500 after September 22, 1996?** YES NO

If Yes, under what name? _____ Where? _____ When? _____

DO NOT FILL OUT QUESTIONS 26-29 UNLESS OTHERWISE INSTRUCTED BY YOUR DHS WORKER DURING YOUR INTERVIEW. PLEASE CONTINUE TO SIGNATURE BOX ON PAGE 14 OF 14. YOU MUST SIGN THE APPLICATION BEFORE SUBMITTING.

To determine ongoing benefit eligibility, you must sign and complete both PART I & PART II of this application. Bring or send in the required documentation to determine ongoing benefits.

Agency Note: The questions below are only required for households with a member who has committed an Intentional Program Violation, households with members who are in a work sanction, and/or elderly and disabled households with gross income above 200% of the poverty level.

26. Does anyone in your household have any resources/assets such as the types listed below? YES NO

If yes, fill in the information below for all household members including children.

CASH/BANK/RESO
VER

Examples include but are not limited to: Cash, Checking, Savings, Credit Union Account, Stocks, Bonds, Certificates of Deposit, Life Insurance, Trust Fund, Money Market Account, Saving Certificate or other items of value. Also list all joint accounts.

NAME	TYPE OF RESOURCE/ACCOUNT	BANK/LOCATION	ACCOUNT NUMBER	VALUE/BALANCE
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

27. Does anyone in the your household own any cars, trucks, boats, campers, motorcycles, snowmobiles, trailers, ATV's, etc? YES NO

If yes, complete the information below:

CARS
VER

OWNER/ CO-OWNER	MAKE (Ford, Chevy, etc.)	MODEL (Taurus, Blazer, etc.)	AMOUNT OWED
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

28. Other than the house that you live in, is there any land, buildings, or homes owned by anyone in your household? YES NO

If yes, complete the information below:

PROP
VER

Owner: _____ Type/Location _____ Value \$ _____ Amount Owed _____ For Sale/Rental? YES NO
 How is the property owned? Solely Jointly Other
 Owner: _____ Type/Location _____ Value \$ _____ Amount Owed _____ For Sale/Rental? YES NO
 How is the property owned? Solely Jointly Other
 Owner: _____ Type/Location _____ Value \$ _____ Amount Owed _____ For Sale/Rental? YES NO
 How is the property owned? Solely Jointly Other

29. Has anyone in your household sold, traded, or given away anything of value within the last 3 months? (money, land, vehicles, buildings, house, etc.) YES NO

If yes, complete the information below.

TRAN
VER

Name _____ What Was Transferred? _____ Date Transferred _____ Value \$ _____
 Name _____ What Was Transferred? _____ Date Transferred _____ Value \$ _____
 Name _____ What Was Transferred? _____ Date Transferred _____ Value \$ _____

ADDITIONAL INFORMATION
WORKSHEET

Please use this worksheet to include any additional members and/or information. To ensure processing accuracy, write the question number and the application page number your answer pertains to in the space provided.

Name: _____ Last 4 Digits of your Social Security #: _____

Address: _____ Telephone: _____

Question No.	Application Page No.
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Question No.	Application Page No.
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Question No.	Application Page No.
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Question No.	Application Page No.
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Question No.	Application Page No.
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Question No.	Application Page No.
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To complete this application, proceed to the next page.

It is **IMPORTANT** to read the Rights and Responsibilities Pages.

A **SIGNATURE IS REQUIRED** within the "Signature Required" box located on the Rights and Responsibilities Application Page 14 of 14.

ONLY SUBMIT APPLICATION PAGES 1-14 – KEEP ALL "RESOURCE SHEETS"

UNLESS OTHERWISE INSTRUCTED BY YOUR DHS WORKER

RIGHTS AND RESPONSIBILITIES
Applicants/Recipients of the Supplemental Nutrition Assistance Program (SNAP)



You have a RIGHT to appeal and receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. Hearing forms, on which you may file your complaint, are available in every local and State Department office. If you are not satisfied with any Department decision regarding your application, you have a right to request a hearing. You must request a hearing within 90 days from the date that you receive a written notice for SNAP benefits.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), and the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84), and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or sex in acceptance for or provision of services, employment or treatment, in its educational and other programs and activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation.

For further information about these laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 57 Howard Avenue, Cranston, RI 02920, telephone number 462-2130 (TDD 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS' civil rights compliance.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or because all or a part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department (Not all prohibited bases will apply to all programs and/or employment activities). If you wish to file a complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to use by mail at the U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact that USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm. USDA is an equal opportunity provider and employer. **You have a RIGHT** to confidentiality. The Department uses information about you and other members of your household only for purposes directly related

to the administration of the programs and in compliance of the Health Insurance

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the household, to act on behalf of the household in applying for program benefits, or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and SNAP Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

You have a RESPONSIBILITY to supply the Department with accurate information and provide proof about your income, resources and living arrangements.

You have a RESPONSIBILITY to tell us immediately (within ten (10) days) of any changes in your income, resources, family composition, or any other change that affects your household. For SNAP, if you are a simplified reporter, you must report when your income exceeds 130% of the Federal Poverty Level. If you are unsure about your reporting requirements, contact your DHS worker.

You have a RESPONSIBILITY to provide social security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of information on the application, including the social security numbers of each household member for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036. This information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP.

The Department will verify this information through computer matching programs with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

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

RIGHTS AND RESPONSIBILITIES
Applicants/Recipients of the Supplemental Nutrition Assistance Program (SNAP)
(Continued)

You have a RESPONSIBILITY to report and provide proof of your expenses in order for you to receive the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

You have a RESPONSIBILITY to cooperate fully with State and Federal personnel conducting quality control reviews.

Only U.S. citizens and certain legal immigrants may be eligible for SNAP benefits. If there are non-citizens living with you who are not eligible, you may still apply for and receive benefits for other eligible household members. You are not required to provide immigration information for people not applying for benefits but you may need to provide other information for those people, such as, income and resources.

DECLARATION OF APPLICANT/RECIPIENT SNAP PENALTY WARNINGS - I understand that:

1. Any member of my household who intentionally breaks a SNAP rule can be barred from the SNAP for one year to permanently, fined up to \$250,000, imprisoned up to 20 years or both. S/he may also be subject to prosecution under other applicable Federal and State laws. S/he may also be barred from the SNAP for an additional 18 months if court ordered. Any member of my household who intentionally breaks a SNAP rule can be barred from the SNAP Program: ***For a period of one (1) year for the first violation, with the exceptions in numbers 2 and 3 below; *For a period of two (2) years after the second violation, with the exception in number 3. Below; and, *Permanently for the third occasion of any intentional program violations.**

2. Individuals found by a Federal, State, or local court to have used or received SNAP benefits in a transaction involving the sale of firearms, ammunitions or explosives shall be permanently ineligible for the SNAP program upon the first occasion of such violation.

3. Individuals found by the Department of having made, or convicted in a Federal or State court of having made, a fraudulent statement or

representation with respect to their identity or place of residence in order to receive multiple benefits simultaneously under the SNAP program would be ineligible to participate in the program for a ten (10) year period.

4. Individuals found guilty by a court of law of using or receiving benefits in a transaction involving the sale of a controlled substance will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

5. Individuals found guilty by a court of law for buying and selling illegal drugs or certain prescription drugs in exchange for SNAP benefits will be prohibited from participating in the SNAP for 24 months for the first offense and permanently for the second offense.

6. An individual convicted by a Federal, State or local court of having trafficked benefits for an aggregate amount of \$500 or more shall be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.

DO NOT give false information or hide information to get or continue to get SNAP benefits.

DO NOT trade or sell EBT cards.

DO NOT use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

DO NOT use someone else's EBT card for your household.

DO NOT pay for food purchased on credit with SNAP benefits. Doing so could result in disqualification from the program.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.

DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in this Penalty Warning.

****Signature Required****

By signing this application, I certify under penalty of perjury that I have read (or have had read to me) and understand the Notice of Rights, Responsibilities and Penalties, and that my answers are correct, and complete to the best of my knowledge and belief. I know that under State of RI General Laws, Section 40-6-15, a maximum fine of \$1,000 or imprisonment for up to 5 years, or both may be imposed for a person who obtains, attempts to obtain, or aids or abets any person to obtain public assistance to which s/he is not entitled or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Person Helping You Complete This Form	Date
Signature of Guardian, Conservator or Holder of Power of Attorney	Date	Signature of Agency Representative	Date

DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL

THE EXAMPLES provided below are to help you get ready for your interview with your DHS worker.

Please COPY only the documents needed to complete your application or re-certification.

For a TELEPHONE INTERVIEW, you must send in copies of the required documents to your DHS worker BEFORE the scheduled interview date.

For an IN OFFICE INTERVIEW, BRING in the required documents with you.

If you need help obtaining or copying any of these documents, please call the DHS worker listed on your appointment letter, or visit your local community action agency. See back page of application for locations and contact numbers.

VERIFICATION OF:

DOCUMENTS YOU MAY NEED:

CHILD SUPPORT PAID

A copy of the court order and proof of the amount paid, such as a canceled check or a written statement.

DEPENDENT CARE EXPENSES

Receipt showing your out-of-pocket child/adult care expenses.

EARNED INCOME

Most recent pay stubs (4 or more weeks), including tips and commissions if applicable, or a letter from your employer showing gross income and hours worked (self-employment – previous years tax return)

IDENTIFICATION

An applicant and or authorized representative will need at least ONE form of identification such as: Passport or Certificate of Naturalization; driver's license; birth certificate; voter registration card; military or RI state ID card; work or school ID card; health benefit card or a library card. A Social Security number for all household members applying for benefits is required.

(Social Security cards are not required.)

IMMIGRATION STATUS

If a NON CITIZEN, proof of immigration status is required and sponsorship information may be needed.

MEDICAL EXPENSES

INDIVIDUALS WITH A DISABILITY OR AGE 60 OR ABOVE: medical costs including, medical bills NOT REIMBURSED, prescription costs, Medicare card showing "Part-B" and "Part-D" coverage.

RESIDENCY

One document indicating current address (i.e. utility bill, bank statement, etc.)

RESOURCES

In SOME CASES resources may apply. They include verification of liquid resources, bank statements, stock and bond certificates and proof of property ownership. Vehicle registration may be required.

SHELTER COSTS

Rent receipt, mortgage payment statement, rent/lease agreement, statement from HUD, statement from person who shares shelter costs, utility bills, statement from utility company, statement from landlord.

STUDENT INCOME (LOAN / GRANT / SCHOLARSHIP)

An applicant may be required to provide verification of educational expenses including, but not limited to, tuition and fees.

UNEARNED INCOME

Most recent copy of Social Security award letter; proof of unemployment; Workers' Compensation; pension; child support; alimony; TDI; rental income; dividends or any interest income; adoption subsidy; Earned Income Tax Credit; foster care income; school loans, grants, scholarships; out of state assistance.

What Happens Next?

ONLY SUBMIT APPLICATION PAGES 1-14 - KEEP ALL "RESOURCE SHEETS" UNLESS OTHERWISE INSTRUCTED BY YOUR DHS WORKER.

Once you have submitted an application for SNAP benefits, the Department of Human Services (DHS) has **30 days** to determine your eligibility. If you have less than \$100 in cash, and less than \$150 in monthly earnings, or if your housing expenses exceed your monthly income, DHS is required to review your application and make a decision within 7 days.

1. You must have an interview with DHS
2. You will receive a notice in the mail informing you of the date and time of the interview.
 - If you requested a telephone interview, your DHS worker will call you at the phone number you provided on the application.
 - If you requested an office interview, go to the appropriate office at the time of your interview.
 - If you cannot make the interview (phone or in-office) at the scheduled date and time, call the office immediately to reschedule.
3. You will need to gather documents verifying your situation. You may provide photocopies.
 - If you have a telephone interview, mail or fax your documents before the interview
 - If you have an in-office interview, bring your documents with you to the office.
 - If you are asked to provide further documentation you have ten days to get it to DHS.
4. If you are approved you will be given or mailed an EBT card and asked to select your personal identification number.
5. If you are denied you have a right to appeal the decision. Speak with your DHS worker about that.

Your DHS Office Depends On Where You Live:

NEWPORT, 272 Valley Road, Middletown, RI 02842, 851-2100 (ph), 851-2105(fax) if you live in: Jamestown, Little Compton, Middletown, Newport, Portsmouth and Tiverton

PAWTUCKET, 249 Roosevelt Avenue, Pawtucket, RI 02860, 721-6600 (ph), 721-6659(fax) if you live in: Barrington, Bristol, Central Falls, East Providence, Pawtucket, Warren

PROVIDENCE, 206 Elmwood Avenue, Providence, RI 02907, 415-8200 (ph), 415-8349 (fax) if you live in: Cranston, Johnston, Providence, Scituate

WAKEFIELD, 4808 Tower Hill Road, Wakefield, RI 02879, 782-4300 (ph), 782-4316 (fax) if you live in: Charlestown, Coventry, East Greenwich, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, West Greenwich, Westerly

WARWICK, 195 Buttonwoods Ave, Warwick, RI 02886, 736-1400 (ph), 736-1443 (fax) if you live in: Warwick, West Warwick

WOONSOCKET, 450 Clinton Street, Woonsocket, RI 02895, 235-6200 (ph), 235-6237 (fax) if you live in: Burrillville, Cumberland, Foster, Glocester, Lincoln, North Providence, North Smithfield, Smithfield, Woonsocket

SNAP APPLICATION

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) INCOME GUIDELINES (Formerly Known as the Food Stamp Program)



The majority of applicant households may be determined categorically eligible for SNAP if household Gross Income is at or below 185% the federal poverty level. Additionally, households that have a member who is over age 59 or disabled with household Gross Income at or below 200% of the federal poverty level may be determined categorically eligible. All households must receive a TANF –funded service such as the RI Department of Human Services Information Publication to be categorically eligible. The monthly gross income limits listed below are from October 1, 2014 through September 30, 2015 and are adjusted annually.

2014-2015 SNAP Monthly Gross Income Limits			
Household Size	100% FPL Net Income	Categorically Eligible	Elderly and Disabled Households
		185% FPL Gross Income	200% FPL Gross Income
1	\$ 973	\$1,800	\$1,946
2	\$1,311	\$2,425	\$2,622
3	\$1,650	\$3,053	\$3,300
4	\$1,988	\$3,678	\$3,976
5	\$2,326	\$4,303	\$4,652
6	\$2,665	\$4,930	\$5,330
Each Additional	+\$339	+ \$627	+ \$678

A household that meets the Gross Income guidelines as listed above must then meet the Net Income guideline in order to receive a monthly SNAP benefit. Net Income is calculated as Gross Income minus allowable deductions.

The following deductions will be allowed in determining Net Income:

- A standard deduction based on household size
- An earned income deduction (20% of earned income)
- The cost of child/dependent care
- A portion of shelter expenses up to a standard amount
- Households where someone is elderly or disabled may also deduct a portion of their monthly medical expenses

Important Note Regarding Eligibility: A small percentage of applicant households may qualify for SNAP, but not be determined categorically eligible. These may include elderly and disabled households whose income is above 200% the FPL as well as households sanctioned by DHS for a program violation. Such applicants should contact the Rhode Island Department of Human Services at 401-462-5300 for further eligibility information.



SNAP Outreach staff is available to answer questions about SNAP, help you to figure out if you may be eligible and help you to complete a SNAP application. They will be glad to talk with you about your situation or let you know how to support a friend or loved one. If you have any questions, call the telephone number listed above.



Call our helpline at **1-877-Food-URI** for advice on healthy eating, low cost recipes, and tips to stretch your food dollar. You can also request our brochure listing meal site and food pantry locations.

If you receive benefits, you may be entitled to a lower telephone or electric bill.

Lifeline Telephone Assistance Program

If you are found eligible for SNAP benefits, you may be eligible to receive a monthly discount on your telephone bill. For more information on how to obtain this discount, contact the **DHS Helpline at 401-462-5300.**



EBT Transaction Assistance



Check your SNAP and RIWORKS EBT balances and transactions online, anytime, any day from any computer. Just log on to this web site: <http://www.ebtedge.com> and “click” **Cardholder Login** or call **1-888-979-9939.**

Electricity Assistance

National Grid provides a discount rate to all eligible SNAP recipients. To get the utility discount, please submit the most recent copy of your SNAP eligibility to National Grid. For more information on how to obtain this discount, contact the **DHS Helpline at 401-462-5300.**



CAP Agencies and Heating Assistance



<http://www.ricommunityaction.org>

The Rhode Island Community Action Programs (CAP Agencies) provide services to economically disadvantaged and working poor families such as housing, heating assistance, employment, education, basic and emergency needs, and financial services. Call your local CAP agency for assistance:

		Office
Blackstone Valley CAP	723-4520	Pawtucket
Comprehensive CAP	467-9610	Cranston
Lower East Bay CAP	437-1000	Newport
Upper East Bay CAP	847-7821	E. Providence
Family Resources	766-0900	Woonsocket
Providence CAP	273-2000	Providence
South County CAP	789-3016	Wakefield
Tri Town CAP	351-2750	Johnston
West Bay CAP	732-4666	Warwick

General Assistance: United Way 2-1-1



After School Programs; Alzheimer’s resources; Basic Needs- food, clothing, shelter, etc; child care/ child health services; consumer protection; counseling; crisis intervention; disability services; domestic violence programs; donating food, clothing, furniture, etc; emergency shelter; energy / utility assistance; family counseling; financial assistance; health care/ insurance; HIV/AIDS testing; homelessness; housing or rent assistance; job training; legal assistance; mentoring opportunities; parent education programs; problem gambling; senior services/ elder care; substance abuse programs; suicide prevention; transportation assistance; veterans’ services; volunteer opportunities and much more... Call 211.

Elderly and Adults with Disabilities

THE POINT provides information, referrals and help getting started with programs and services for seniors, adults with disabilities and their caregivers. **Call 401-462-4444.**

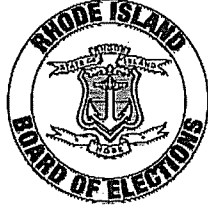
Executive Office of Health and Human Services

401-462-2121 <http://www.eohhs.ri.gov>



Department of Children, Youth and Families	401-528-3502	http://www.dcyf.ri.gov
Division of Elderly Affairs	401-462-3000	http://www.dea.ri.gov
Department of Human Services		
• Long Term Services and Supports, Medical, Cash, Food & Childcare	401-462-5300	http://www.dhs.ri.gov
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	401-462-3201	http://www.bhddh.ri.gov

State Service Providers: RI Coalition Against Domestic Violence 401-467-9940; RI Coalition for the Homeless 401-721-5685; Victims of Crime 24- Hour Helpline 1-800-494-8100; State Relay Dial 7-1-1



Notice to Applicant Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.
- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.
- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.
- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.



RHODE ISLAND

VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
(You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: REQUIRED. Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

1. Check Boxes that Apply: <input type="checkbox"/> New Voter Registration <input type="checkbox"/> Address Change <input type="checkbox"/> Party Change <input type="checkbox"/> Name Change					
2. I am a U.S. Citizen and resident of Rhode Island. <input type="checkbox"/> Yes <input type="checkbox"/> No I am at least 16 years of age. (You must be at least 18 years of age to vote.) <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked NO to either of these statements, do not complete this form.		3. RI driver's license or ID Number: <input type="text"/> If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: <input type="text"/> If you do not enter either number, see instructions for Box 3.			
4. Last Name		Suffix (if any)	First Name	Middle Name (or initial)	
5. Home Address (Do not enter a post office box)		Apt.	City/Town	State RI	ZIP Code
6. Mailing Address (If different from Box 5)		Apt.	City/Town	State	ZIP Code
7. Date of Birth (mm/dd/yyyy)	8. Phone No./ E-mail Address (optional)		9. Party Affiliation: <input type="checkbox"/> Americans Elect <input type="checkbox"/> Democrat <input type="checkbox"/> Moderate <input type="checkbox"/> Republican <input type="checkbox"/> Unaffiliated <input type="checkbox"/> Other _____		
10. I swear or affirm that: - I am not incarcerated in a correctional facility upon a felony conviction. - I am not presently judged "mentally incompetent" to vote by a court of law. - The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.			Official Use For Barcode		
PLEASE SIGN FULL NAME OR PLACE MARK BELOW <input style="width: 100%; height: 20px;" type="text"/>			Are you interested in working at the polls? (check box below) <input type="checkbox"/>		
Warning: If you sign this form and know it to be false, you can be convicted and fined up to \$5,000 or jailed up to 10 years.			Date: _____ (mm/dd/yyyy) Signed _____		
11. PREVIOUS NAME (if different from Box 4)		12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County)			

Return Address



Postage
Required Post
Office will not
deliver
without proper
postage.

Mail To: **BOARD OF CANVASSERS**

*****FOLD HERE & TAPE AT TOP*****

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "Mail To: BOARD OF CANVASSERS" on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

LOCAL BOARDS OF CANVASSERS

- | | | | |
|--|--|--|---|
| Barrington Town Hall, 283 County Rd.,
Barrington, RI 02806 | Exeter Town Hall, 675 Ten Rod Rd.,
Exeter, RI 02822 | New Shoreham Town Hall, PO Drawer,
220 Block Island, RI 02807 | Smithfield Town Hall, 64 Farnum Pike,
Smithfield, RI 02917 |
| Bristol Town Hall, 10 Court St.,
Bristol, RI 02809 | Foster Town Hall, 181 Howard Hill Rd.,
Foster, RI 02825 | Newport City Hall, 43 Broadway,
Newport, RI 02840 | S. Kingstown Town Hall, 180 High St.,
Wakefield, RI 02879 |
| Burrillville Town Hall, 105 Harrisville
Main St., Harrisville, RI 02830 | Glocester Town Hall 1145 Putnam Pike
PO Drawer B, Glocester, RI 02814 | N. Kingstown Town Hall, 80 Boston
Neck Rd., North Kingstown, RI 02852 | Tiverton Town Hall, 343 Highland Rd.,
Tiverton, RI 02878 |
| Central Falls City Hall, 580 Broad St.,
Central Falls, RI 02863 | Hopkinton Town Hall, 1 Town House
Rd., Hopkinton, RI 02833 | North Providence Town Hall, 2000
Smith St., North Providence, RI 02911 | Warren Town Hall, 514 Main St., Warren,
RI 02885 |
| Charlestown Town Hall, 4540 S. County
Trail, Charlestown, RI 02813 | Jamestown Town Hall, 93 Narragansett
Ave., Jamestown, RI 02835 | North Smithfield Municipal Annex, 575
Smithfield Rd., North Smithfield, RI
02896 | Warwick City Hall, 3275 Post Rd.,
Warwick, RI 02886 |
| Coventry Town Hall, 1670 Flat River
Rd., Coventry, RI 02816 | Johnston Town Hall, 1385 Hartford
Ave., Johnston, RI 02919 | Pawtucket City Hall, 137 Roosevelt
Ave., Pawtucket, RI 02860 | W. Greenwich Town Hall 280 Victory
Highway, W. Greenwich, RI 02817 |
| Cranston City Hall, 869 Park Ave.,
Cranston, RI 02910 | Lincoln Town Hall, 100 Old River Rd.,
PO Box 100, Lincoln, RI 02865 | Portsmouth Town Hall, 2200 East Main
Rd., Portsmouth, RI 02871 | West Warwick Town Hall, 1170 Main St.,
West Warwick, RI 02893 |
| Cumberland Town Hall, 45 Broad St.,
Cumberland, RI 02864 | Little Compton Town Hall, PO Box 226,
Little Compton, RI 02837 | Providence City Hall, 25 Dorrance St.,
Providence, RI 02903 | Westerly Town Hall, 45 Broad St.,
Westerly, RI 02891 |
| East Greenwich Town Hall, PO Box 111,
East Greenwich, RI 02818 | Middletown Town Hall, 350 East Main
Rd., Middletown, RI 02842 | Richmond Town Hall, 5 Richmond
Townhouse Rd., Wyoming, RI 02898 | Woonsocket City Hall, P.O. Box B,
169 Main St., Woonsocket, RI 02895 |
| East Providence City Hall,
145 Taunton Ave.,
East Providence, RI 02914 | Narragansett Town Hall, 25 Fifth Ave.,
Narragansett, RI 02882 | Scituate Town Hall, PO Box 328, North
Scituate, RI 02857 | |

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov