



Assistance Application

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

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

Apply online: www.michigan.gov/mibridges

← Refer to the Information Booklet for details on each program

Welcome!

Fill out the Assistance Application

Answer questions about you and your household.

Fill out Program Details:



Healthcare Coverage



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?

Arabic Language

Native 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, hagáenos 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

Case #:

ID #:

Applicant Registration

If you are unable to finish the entire application today, you may complete this page and return it to MDHHS. MDHHS will still need to receive your completed application before any benefits can be approved

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

_____ Homeless
Legal Name (First, Middle, Last)

_____ Apt/Lot #
Household Street Address — the place where you currently live

_____ City _____ County _____ State _____ ZIP Code

_____ Mailing Address — if different from above (Street, City, County, State, ZIP Code)

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

_____/_____/_____-____-_____
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 and get official information about this application. For Healthcare only, I authorize my Authorized Representative to act for me on all future matters.

Signature of Applicant

Signature of Representative

Date

Household Members

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 US 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 #	US 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):	Hispanic/Latino Not Hispanic/Latino	Race (optional):		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):	Hispanic/Latino Not Hispanic/Latino	Race (optional):		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):	Hispanic/Latino Not Hispanic/Latino	Race (optional):		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):	Hispanic/Latino Not Hispanic/Latino	Race (optional):		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):	Hispanic/Latino Not Hispanic/Latino	Race (optional):		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

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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? (circle all) _____ **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? (Circle all that apply)

If yes, who? _____ **No**

Foster Child Foster Parent Adopted Child Non-parent Caregiver

Is anyone in your household currently a victim of domestic violence, victim of trafficking, migrant farmworker, seasonal farmworker, or refugee/asylee? (Circle all that apply)

If yes, who? _____ **No**

Victim of Domestic Violence Victim of Trafficking
Migrant Farmworker Seasonal Farmworker Refugee/Asylee

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
	<u>Citizen and wife</u>	#	/ /
		#	/ /
		#	/ /

Need more room to write? Go to notes on last page.

Yes, I've added more notes.

Assets

This page is not required for Child Care (CDC)

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

Please include jointly owned accounts and/or assets

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

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

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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

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)			
			\$	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	
		\$		\$	
		\$		\$	
		\$		\$	

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/Spousal Support 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 Refugee Match Grant Short Term/Long Term Disability

Who?	Type of Income	Amount Received			
		\$	per Wk	2Wks 2x/Mo Mo Yr	
		\$			
		\$			

Expenses

This page is not required for Child Care (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

Health Insurance Prescriptions In-Home Care Hospital Bills Other
 Co-Pays Dental Transportation for Care Guardian/Conservator Expenses

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

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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 period?

_____ If yes, who? _____ No

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

_____ If yes, who? _____ No

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 and get information from MDHHS. For Healthcare only, I authorize my Authorized Representative to act for me on all future matters. 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)

