OKLAHOMA Human Services

Office:
Address:
City: State: Zip:

Renew My Benefits

Date: _____
Case name: _____
Case number: _____
County number: _____
Supervisor/worker #: _____

Recipient:
Address:
Extra Address:
City: State: Zip:

Case Information

_____ _____
Case name Social Security number

Oklahoma Human Services (OKDHS) staff uses the information you report on this form to see if your household can still get help with food, SoonerCare (Medicaid), or child care subsidy benefits. Please fill out, sign, and return this form to the OKDHS office shown above. Attach additional sheets of paper to this form if you need more space to answer questions. Return this form by _____ or your benefits will stop on _____ .

If you need help filling out this form, call your OKDHS office. [Nota Importante: Si usted no puede leer esta forma, póngase en contacto con su trabajador social, llamando al número de teléfono que se menciona arriba.]

If you want help filling out a voter registration application form, call 1-855-880-8003 for assistance.

Tell Us About Where You Live

_____ _____ _____ _____
Mailing address City State ZIP code

_____ _____ _____ _____
Street address City State ZIP code

_____ _____ _____ _____
Home phone Work phone Cell phone Message phone

_____
Email address

Finding directions to your home

People Getting Benefits Now

List the people getting benefits in your case:

Name: _____ Still live with you? ☐ Yes ☐ No

Military status, check one:

☐ active duty military ☐ former military ☐ National Guard/Military Reserve ☐ none

Name: _____ Still live with you? ☐ Yes ☐ No

Military status, check one:

☐ active duty military ☐ former military ☐ National Guard/Military Reserve ☐ none

Name: _____ Still live with you? ☐ Yes ☐ No

Military status, check one:

☐ active duty military ☐ former military ☐ National Guard/Military Reserve ☐ none

Name: _____ Still live with you? ☐ Yes ☐ No

Military status, check one:

☐ active duty military ☐ former military ☐ National Guard/Military Reserve ☐ none

Name: _____ Still live with you? ☐ Yes ☐ No

Military status, check one:

☐ active duty military ☐ former military ☐ National Guard/Military Reserve ☐ none

Tell Us About Other People Living in Your Home

Please fill out the information below for everyone else living in your home that is not already shown above. If you want benefits for him or her, you must check the United States (U.S.) citizen block and fill in the Social Security number for each person. OKDHS staff will contact you. Providing race and ethnic background information is voluntary and does not affect your eligibility or benefit amount. This information is used to assure that program benefits are distributed without regard to race, color or national origin. The U.S. Department of Agriculture (USDA) requires us to answer these questions for you if you do not provide this information.

_____ _____ _____

Name Date of birth Relationship to you

Gender U.S. Citizen? Hispanic or Latino?

_____

Social Security number ☐ M ☐ F ☐ Yes ☐ No ☐ Yes ☐ No

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

_____ _____ _____

Name Date of birth Relationship to you

Gender U.S. Citizen? Hispanic or Latino?

_____

Social Security number ☐ M ☐ F ☐ Yes ☐ No ☐ Yes ☐ No

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

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Name _____ Date of birth _____ Relationship to you _____

Social Security number _____ Gender ☐ M ☐ F U.S. Citizen? ☐ Yes ☐ No Hispanic or Latino? ☐ Yes ☐ No

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Tell Us About Your Household's Income

Income is all the money you and the people living with you get each month. Types of income include money earned from working for someone else, working for yourself, and any unearned income.

Some types of unearned income are: child support, Social Security, Supplemental Security Income (SSI), State Supplemental Payment (SSP), Temporary Assistance for Needy Families (TANF), Tribal TANF, veteran's benefits (including a pension, disability compensation, retirement, Aid and Attendance, and/or veteran's benefits for dependents, or a deceased family member's benefit), unemployment benefits, military allotments, alimony, gambling or lottery winnings, Workers' Compensation, contributions, student income, interest, dividends, pension or retirement income from any source, rental income, foster care or adoption subsidy payments, and income from mineral rights or oil and gas leases, and personal loans.

Tell us about your household's income for the month of _____ .

If income stopped, fill out the information below:

Name	Income type	Final amount	Date of final amount

If you have income, fill out the information below:

Name of person getting income _____ Amount before taxes _____ How often received _____

Income type _____ Self-employment gross income last year _____

Employer _____ Employer phone number _____

Employer address _____

Name of person getting income _____ Amount before taxes _____ How often received _____

Income type

Self-employment gross income last year

Employer

Employer phone number

Employer address

Name of person getting income

Amount before taxes

How often received

Income type

Self-employment gross income last year

Employer

Employer phone number

Employer address

If anyone 16 years of age or older is a student, please fill out the information below:

Student name	Full or part time?	School name

Tell Us About Your Bills and Expenses

Please fill out the information below about your bills and expenses:

Child care expense

How much do you pay each month for child care?

Adult day care expense

How much do you pay each month for day care for an elderly or disabled person who lives with you?

Medical expense

Tell us the medical costs not paid by insurance for everyone who is disabled or age 60 and older. These could be doctor or hospital bills, medicine, transportation, health insurance premiums, or other medical services.

Name	Expense type	Monthly expense

Child support expense

Does anyone in your household pay court-ordered child support? ☐ Yes ☐ No

If yes, please fill out the information below:

Who pays support? _____ How much? _____ How often? _____

Who gets support? _____ Phone number of person receiving support _____

Housing expenses

Do you get help to pay for housing? ☐ Yes ☐ No

When yes,

Who pays? _____ To whom? _____ How much? _____

Do you or anyone in your household pay for housing? ☐ Yes ☐ No

How much do you pay for housing? Amount _____ per _____

Homeowner insurance, if separate: Amount _____ per _____

Property tax, if separate: Amount _____ per _____

Person or company you pay rent/mortgage to: _____

What is his or her phone number? _____

Do you expect to pay the same amount for housing next month? ☐ Yes ☐ No

If you consider yourself **homeless**, do you have any shelter costs associated with being homeless such as living in a car and having a car payment, giving a friend money to sleep in their home, paying camping fees, or hotel/motel charges? ☐ Yes ☐ No

If yes, how much do you spend for these expenses? _____

Utility expenses

Are you responsible for paying heating or cooling expenses? ☐ Yes ☐ No

What utility expenses do you pay:

☐ Electric ☐ Garbage/water ☐ Gas/butane/propane ☐ Phone ☐ Wood

☐ Other _____

Do you get help to pay for utility costs such as a utility allowance, tribal assistance, or help from a friend or relative? ☐ Yes ☐ No

If yes, who pays? _____ To whom? _____ How much? _____

Enter utility account information if your heating or cooling cost is not included in your rent.

Natural gas

Company name _____ Account number _____

Account name, as shown on your bill

When the account is not in your name, explain why

Address where the gas or electric meter is located | City | State | ZIP code

Electric

Company name

Account number

Account name, as shown on your bill

When the account is not in your name, explain why

Address where the gas or electric meter is located | City | State | ZIP code

Tell Us About Your Resources

A resource is anything anyone owns, owns jointly with someone else, or is buying that can be sold, traded, or changed into cash. Do not report personal property, such as jewelry, furniture, household appliances, or clothing.

Check the boxes for the resources you have:

- ☐ Checking accounts
- ☐ Savings accounts
- ☐ Stocks/bonds
- ☐ Prepaid burial policies
- ☐ Life insurance
- ☐ Trust funds
- ☐ Individual retirement account (IRA)
- ☐ Mineral rights
- ☐ Livestock
- ☐ Certificate of deposit (CD)
- ☐ Land
- ☐ Property other than your home
- ☐ Cash/DHS issued debit card account balance
- ☐ Other: _____

Report all vehicles here. List all cars, trucks, boats, vans, campers, motorcycles, or other vehicles owned by household members.

Make	Model	Year	Loan balance

Tell Us About Your Health Insurance

Is anyone covered by health or dental insurance? ☐ Yes ☐ No

If yes, please complete the following: If more space is needed, attach additional pages.

Who is covered? | Insurance type | Effective Date | Name of insurance comany

Address of insurance company | City | State | Zip code

Policy holder name | Policy Number | Relationship to insured

Health and dental screening

People under 21 years of age who have SoonerCare (Medicaid) can receive health and dental screening exams and follow-up treatment under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. If you want EPSDT, call your medical provider to set up an appointment. Please check no if you DO NOT want EPSDT services. ☐ No

Tell Us About Your Need for Child Care

Which children need child care? _____

Please fill-in the name of each parent/caretaker, the reason you need child care and the days and hours for the reason checked:

Parent/caretaker name: _____

Reason:

☐ Work ☐ school ☐ training ☐ protective/preventive ☐ TANF work

☐ Other: _____

Days and hours:

☐ Monday from ____ to ____ ☐ Friday from ____ to ____

☐ Tuesday from ____ to ____ ☐ Saturday from ____ to ____

☐ Wednesday from ____ to ____ ☐ Sunday from ____ to ____

☐ Thursday from ____ to ____

Parent/caretaker name: _____

Reason:

☐ Work ☐ school ☐ training ☐ protective/preventive ☐ TANF work

☐ Other: _____

Days and hours:

☐ Monday from ____ to ____ ☐ Friday from ____ to ____

☐ Tuesday from ____ to ____ ☐ Saturday from ____ to ____

☐ Wednesday from ____ to ____ ☐ Sunday from ____ to ____

☐ Thursday from ____ to ____

Who is your child care provider?

Name	Address	Phone number

Is anyone other than you or OKDHS currently paying any money directly to your child care provider? ☐ Yes ☐ No

If yes, list name and how much he or she is paying:

Name _____ Amount _____

Who is your emergency contact?

Name _____ Phone number _____

Does your household have resources over $1,000,000? ☐ Yes ☐ No

Proof Needed

You MUST give us proof of all income if any member of your household:

- receives SNAP (food benefits), child care benefits, or Temporary Assistance to Needy Families (TANF), or
- receives SoonerCare (Medicaid) and is disabled or 65 years of age or older.

You MUST give us proof of all resources if any member of your household:

- receives SoonerCare (Medicaid) and is disabled or 65 years of age or older.

You may upload the documents listed below directly to your case record by opening the www.okdhslive.org website, clicking on the "Fast Pass Verification Upload" option, logging in, choosing the "Upload Verification" option, and uploading one document or page at a time.

If anyone:	then you must attach:
is working	○ pay stubs for all checks anyone received in the last 30 days; or ○ statements from employers showing pay dates and earnings before taxes received in the last 30 days.
has stopped working in the last five months	○ final pay check stub and employer's statement.
is self-employed	○ a federal income tax return for the previous year; or ○ income and expense records if taxes have not been filed.
gets unearned income	○ an award letter; ○ a letter from the person or agency who provides the income; ○ a check stub or copy of check; or ○ a court order.

has stopped getting unearned income	○ a statement from the person or agency that gave you the income showing it has stopped.
has resources (SoonerCare/ Medicaid only)	○ checking and savings account statements, debit card balance statement, or other financial statements from the past 30 days; ○ copy of current cash and face value of all life insurance policies you own; ○ copy of burial policy if not given to OKDHS before; or ○ copy of current cash and face value of all burial policies you own; ○ copy of property deeds and titles, if not given to us before; or ○ proof of closure of any financial accounts within the last year.
has vehicles, such as cars, trucks, boats, vans, motorcycles, RVs, or campers	○ proof of amount owed on loans.
gets child care subsidy benefits	○ proof of your current work/school/training schedule.
has expenses (Food Benefits only) for:	
Housing/shelter costs paid by the household*	○ rent/lease agreement; ○ mortgage statement; ○ housing authority paperwork; ○ name and phone number of the landlord; ○ insurance and property taxes if paid separate from mortgage.
Utilities paid by the household*	○ current utility bills.
Medical expenses not paid by insurance for a person over 60 years of age or with a disability*	○ prescription printouts for the past 60 calendar days; ○ insurance premium statements; ○ copy of doctor or hospital bills; ○ statement of transportation costs.
Court-ordered child support paid by a household member to someone outside of the household*	○ court order, if not given to us before; and ○ proof of regular child support payments.
Child care payments, if not receiving child care through OKDHS*	○ letter from the provider with details of how often paid and the amount paid, and payment receipts.

* Only countable expenses that are reported and verified can be used to calculate your SNAP benefits. If an expense is not reported and verified, it will not be counted.

The following information applies to the Supplemental Nutrition Assistance Program (SNAP) only:

I understand there are specific penalties for fraudulent activities, such as hiding information, making false statements, or misusing SNAP benefits. For SNAP, more penalties will result for more serious offenses, such as SNAP trafficking. For most situations, the penalties are loss of or reduction of benefits for:

- **one year for the first offense**
- **two years for the second offense; and**
- **permanently for the third offense.**

The collection of this information, including the SSN of each household member, is authorized under the Food and Nutrition Act of 2008, as amended by the Agriculture Improvement Act of 2018, Sections 2011 2036 of Title 7 of the United States Code. The information is used to determine if my household is eligible or continues to be eligible to participate in SNAP. OKDHS verifies this information through computer matching programs. This information is also 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 there is a food benefit overpayment, the information on this application, including all SSN's, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.**
- **I understand food benefits are prorated from the date of application.**
- **I understand that my household is required to provide the requested information, including the SSN of each household member, to receive food benefits. Failure to provide a household member's SSN will result in the disqualification of that household member instead of denying food benefits to my household.**

The following information applies to the SNAP, SoonerCare (Medicaid), and Child Care Subsidy programs:

I understand failure to complete and return this form with attached proof may result in closure of benefits. I agree to provide the proof necessary to establish continued eligibility.

My answers on this form are true, correct, and complete to the best of my knowledge. I understand my rights and responsibilities and penalty warnings from my last application apply to this renewal.

I understand that the SSN of persons included in the benefits are used to match with income data from other government agencies, such as the Social Security Administration, Internal Revenue Service, Oklahoma Employment Security Commission, and data brokers. Information gathered is used to determine my eligibility for assistance.

I certify under penalty of perjury that I truthfully reported the citizenship status of any additional persons for whom I am requesting benefits. I understand I must advise OKDHS if anyone in my household is not in lawful immigration status.

If OKDHS approves my household for benefits and later determines I made a false claim of U.S. citizenship or lawful immigration status for anyone in my household, OKDHS will file a complaint with the U.S. Attorney, and I may be subject to criminal prosecution.

I authorize the release of any necessary information, documents, or forms to OKDHS from individuals, businesses, schools, banking institutions, data brokers, public or private organizations, Oklahoma state agencies, including personal and/or business income tax returns from the Oklahoma Tax Commission, or federal agencies to determine my eligibility for assistance.

_____ _____

Client, guardian, conservator, or authorized representative signature Date

REMEMBER, for your benefits to continue, you must:

- answer every question that applies to you;
- attach all required proof;
- attach additional sheets of paper you used to answer questions; and
- sign the form and return it to an OKDHS office by _____ or your benefits will stop on _____ .

Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program conducted or funded by the USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance to Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language) should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (found online at: How to File a Complaint, 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**: Food and Nutrition Service, USDA
1320 Braddock Place, Room 334,
Alexandria, VA 22314; or

(2) **fax**: (833) 256-1665 or (202) 690-7442; or

(3) **phone**: (833) 620-1071; or

(4) **email**: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

For any other information dealing with 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 SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.