Branch:	Case number:	Worker ID:
Case name:		SSN:
Due by the 10th of:	Filing date:	

Oregon Department of Human Services
SELF-SUFFICIENCY PROGRAMS

Print

Clear

Employment Related Day Care (ERDC) and Supplemental Nutrition Assistance Program (SNAP) Application

1. Complete this form and send it to your local Oregon Department of Human Services (ODHS) office.
2. Attach proof of what you report. ***Do not wait for this month's pay.*** If you need more room, use an additional sheet of paper.

If you are recertifying your benefits:

Your benefits may get delayed if:

- You return a paper or online application after the 10th of the month, or
- It is incomplete.

Your benefits will stop if you do not start your renewal by the end of the month. ***Other ways to renew:***

- ***Online at https://benefits.oregon.gov/***
- ***Call 1-800-699-9075 to complete renewal by phone***
- ***Call or visit your local SSP, APD, or AAA office***

Let us know if you need:

☐ An interpreter Language I speak: _____

☐ A sign language interpreter

☐ Written materials translated *(what language)*: _____

Materials in: ☐ Braille ☐ Large print ☐ Audio tape ☐ Computer disk ☐ Oral presentation

If you are not registered to vote where you live now, would you like to apply to register to vote today?

☐ Yes ☐ No

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Please check one: ☐ I am requesting child care benefits only ☐ I am requesting food benefits only ☐ I am requesting both child care benefits and food benefits

1.

Name *(last, first, middle initial)*:	Maiden or other names used:		Do you plan to stay in Oregon? ☐ Yes ☐ No	
Home address:	City:	State:	ZIP code:	Phone number:
Mailing address *(if different)*:	City:	State:	ZIP code:	Message number:

If you want to give permission to someone else to apply or get benefits for you, name them here:

Authorized representative:	Name *(last, first, middle initial)*:	Phone number *(include area code)*:

2. **Who lives at this address with you?** List everyone in your household, including yourself, even if you are not re-applying for them. Include unborn child(ren) and due date(s).

***Ethnic — Racial Heritage:** You can choose not to give Ethnicity & Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.
For Ethnicity, (*Ethnic) choose one for each person: **H** — Hispanic or Latino **NH** — Not Hispanic or Latino
For Racial Heritage, (*Race) choose one or more for each person: **B** — Black or African American **A** — Asian **W** — White **I** — American Indian or Alaskan Native **P** — Native Hawaiian or Other Pacific Islander

	Self	Person 1	Person 2	Person 3
Name *(last, first, middle initial)*:				
Relation:	Self			
Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth:				
***Ethnic:**	☐ H ☐ NH	☐ H ☐ NH	☐ H ☐ NH	☐ H ☐ NH
***Race *(circle)*:**	B A W I P	B A W I P	B A W I P	B A W I P
Purchase and prepare meals with you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
U.S. citizen:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Want services for this person?	☐ ERDC ☐ SNAP ☐ None	☐ ERDC ☐ SNAP ☐ None	☐ ERDC ☐ SNAP ☐ None	☐ ERDC ☐ SNAP ☐ None
Social Security number *(only for those who want services)*:				

If there are others living in your home, add on a separate sheet of paper.

3. Are you homeless? ☐ Yes ☐ No
   Homeless could mean living in an emergency shelter, shared housing with another family because of job loss or loss of your housing, in a motel, car, park, public place, campsite or other similar place.
4. Is anyone in the household an active military member? ☐ Yes ☐ No
   If yes, who? _____ ☐ Full time active military ☐ National Guard or Military Reserve Unit
5. Do you need child care for a foster child? ☐ Yes ☐ No
6. Do you have shared custody for any of the children needing care? ☐ Yes ☐ No
7. Do you need child care while you are working, attending classes, or both? ☐ Yes ☐ No
   Class hours can only be covered for a school that is eligible for federal financial aid. If you are 20 years old or younger, high school or GED completion can also be covered. Provide a copy of your registration and class schedule.
8. Are you on medical leave from work for yourself or for a child in your home? ☐ Yes ☐ No
   If yes, name of the child? _____
9. For child care needs, are your children's immunization *(shot)* records up-to-date? ☐ Yes ☐ No
   *For **medical or non-medical exemptions,** submit the Oregon Health Authority Exemption form. **Medical exemptions must include** a doctor's statement and **non-medical exemptions must include** a Vaccine Education Certificate. You can find the exemption form and additional information at: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION.*
10. Does anyone have special child care needs? ☐ Yes ☐ No
    If yes, who? _____
11. **My family assets do not exceed one million dollars** *($1,000,000)*. ☐ **Check box if true.**

12. Does anyone work? *(Students include work study.)* ☐ Yes ☐ No

If yes, complete below. List each job for each person who works or is self-employed. **Attach proof** of income received last month and current month. If this is a new job, list date work started: _____.

If self-employed, check here ☐	Job 1	Job 2	Job 3
Person working:			
Employer's name and phone number:			
Job title:			
Hourly pay:	$	$	$
If you are not paid by the hour, explain your income here:			
Hours *(per week):*			
How often paid? *(weekly, monthly):*			
Pay dates:			
Tips per week:	$	$	$
Draws, overtime pay, bonuses or commissions:	$	$	$
Will this income continue?	☐ Yes ☐ No*	☐ Yes ☐ No*	☐ Yes ☐ No*
*If income will change, give the reason for the change here:			
New amount:	$	$	$
Date of the change:			

13. For child care needs, please list information about your work schedule and care providers:

Usual work hours: From: _____ am / pm To: _____ am / pm
Usual work days: ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Usual school hours: From: _____ am / pm To: _____ am / pm
Usual school days: ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Other schedule *(describe)*: _____
Note: If your work schedule varies, give information on the days and times you have worked or attended class. Let us know if you work an overnight shift and need sleep hours.

Please list information about your child care provider:

Provider name	Provider phone	Percentage of hours for provider
1st		
2nd		

Unlicensed providers need to complete a background check and be approved before they are eligible for payment. If you need help finding a provider, contact 211Info by dialing 211, text the keyword "children" to 898211, email children@211.org or visit 211Info.org.

14. Does anyone get money from any other source? ☐ Yes ☐ No

If yes, complete below. **Attach proof of each source**.

Some examples are:
- Social Security
- Interest income
- Unemployment compensation
- Veterans benefits
- Worker's compensation
- Student income/money for school
- Child support
- Loans/gifts
- Winnings

Name of person who got other money	Source of other money	How often paid?	Amount of each payment	Amount this month	Will this income continue?
			$	$	☐ Yes ☐ No*
			$	$	☐ Yes ☐ No*

Name of person who got other money	Source of other money	How often paid?	Amount of each payment	Amount this month	Will this income continue?
			$	$	☐ Yes ☐ No*
* If income will change, give the new amount. What is the reason for the change and when it will change?					

15. Is anyone a student in college, trade school or other training program? ☐ Yes ☐ No
If yes, attach a copy of your Financial Aid Award Letter.

	Student 1	Student 2
Name of student:		
Name of school/training program:		
Type of student:	☐ High school ☐ GED ☐ Graduate ☐ Vocational ☐ Undergraduate	☐ High school ☐ GED ☐ Graduate ☐ Vocational ☐ Undergraduate
Credits:		
Student last term, this term or both?	☐ Last term ☐ This term ☐ Both	☐ Last term ☐ This term ☐ Both
Apply for or get financial aid?	☐ Apply ☐ Getting	☐ Apply ☐ Getting

16. Is anyone in a domestic violence situation or do they need to get away from an abusive or unsafe situation? ☐ Yes ☐ No

17. Does anyone in the household make another household member afraid by threatening, yelling, or physically hurting? ☐ Yes ☐ No

If you are ONLY applying for child care, and NOT food benefits, skip to the middle of page 5. Read and sign page 7

18. Do you pay for child care costs in addition to your copay? ☐ Yes ☐ No
If yes, state monthly amount. $ _____ a month.

19. Do you or anyone in your household pay for housing? ☐ Yes ☐ No
If yes, please complete below: ☐ Rent ☐ Mortgage *(if buying)*

How much do you pay? $ _____ per _____	Fire/hazard insurance, if separate: $ _____ per _____	Property tax, if separate: $ _____ per _____
Person or company you pay rent/mortgage to:	May we contact this person/company? ☐ Yes ☐ No **If yes,** their phone number:	

20. Do you get help to pay for housing? ☐ Yes ☐ No **If yes,** please complete below:

Who pays	Paid to	Amount paid
		$

21. How is your apartment/home heated/cooled? ☐ Wood ☐ Oil ☐ Electric ☐ Gas ☐ Other

a) The expense is: ☐ Included in rent ☐ Paid separately ☐ Paid in a flat amount ☐ Shared with another household ☐ Paid by HUD or other people

b) What other utilities do you pay? _____

22. Does anyone in your home pay court-ordered child support to someone outside your home?
☐ Yes ☐ No **If yes,** please complete below:

Person who pays support	Name of child	Amount paid
		$

23. Is anyone you are applying for 60 years or older or a person with a SSI/SSD disability? ☐ Yes ☐ No
If yes, provide proof of any out-of-pocket medical expenses, including medical insurance expenses.

Person with the out-of-pocket expense	Amount paid
	$_____per month

There are penalties in the Supplemental Nutrition Assistance Program (SNAP) for doing any of the following:

If you do the following…	You will lose Food Benefits…
• Hide information or make false statements; • Use Electronic Benefit Transfer (EBT) cards that belong to someone else; • Use food benefits to buy alcohol or tobacco; • Trade or sell benefits or EBT cards; • Dump containers only for the cash redemption value; • Resell food bought with food benefits for cash.	• 12 months for the first offense; • 24 months for the second offense; • Permanently for the third offense.
• Trade food benefits for controlled substances such as drugs.	• 24 months for the first offense; • Permanently for the second offense.
• Trade food benefits for firearms, ammunition or explosives.	• Permanently.
• Trade, buy or sell food benefits of $500 or more.	• Permanently.
• Give false information about who you are and where you live so you can get extra food benefits.	• 10 years for each offense.
You can also be fined up to $250,000 or put in prison for up to 20 years, or both, for doing these things. You may also be charged under other Federal laws.	
If you knowingly do the following…	**You may be...**
• Use EBT cards which are not yours; • Transfer your EBT cards to other people; • Acquire or possess EBT cards which are not yours.	• Guilty of a felony or misdemeanor; • Fined; • Put in prison; • Ineligible for food benefits for a period of time.

Why we need your Social Security Number (SSN): The Department is authorized to request your Social Security Number (SSN) under 42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), and OAR 461-120-0210. Your SSN will be used to locate your file and records. For clients in only the ERDC program, providing a SSN is voluntary.

Information About Your Rights and Responsibilities

Please read this carefully. You can ask the Oregon Department of Human Services (ODHS) staff to explain this to you. Ask questions if you do not understand. You are agreeing to do certain things when you *(and your spouse or partner)* get benefits from DHS. You may lose benefits if you do not do these things. You may also be asked to repay benefits if you get too many.

Your Rights *(things you can expect from ODHS)*

- ODHS will treat you with respect in a fair and polite way.
- You can ask for a receipt for any form you turn in to the ODHS office.
- I can talk to my worker or a person in charge if I have questions about this form.
- You can ask for the help of an interpreter to help you fill out form or report changes.
- ODHS will give you information in a format or language you can understand.
- ODHS will do its best to meet your special needs if you have a disability. DHS follows the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
- The things you tell ODHS will be kept private and confidential. ODHS follows the "Notice of Privacy Practices" posted in all its offices.
- ODHS will tell you if you qualify for child care benefits within 45 days from the date you file an application.
- ODHS will tell you if you qualify for food benefits within 30 days of the date you file an application.

- You can ask for a hearing if you disagree with a ODHS decision. You can ask for a hearing on the MSC 0443, by phone, in writing or in person. If you get child care benefits, you must ask for a hearing within 45 days of the date on the notice about the decision. For food benefits, you must ask for a hearing within 90 days of the date on the notice.

Your Responsibilities *(things you must do).* By signing this form, I understand and agree that:

- I understand that making false statements or hiding information may mean state and federal penalties.
- ODHS can review my case. This could include coming to my home.
- I declare I am a resident of Oregon.
- I have given true citizenship information about myself and the others I am applying for.
- I know that ODHS will check the immigration status of people who apply for or get benefits. I know the information ODHS gets from the United States Citizenship and Immigration Services (USCIS) could affect who gets benefits. ODHS will not contact USCIS for anyone not seeking benefits.
- I authorize release of my child support records from the Department of Justice (DOJ), Division of Child Support (DCS) to ODHS.
- ODHS may use computers to check all the information on this form. This includes matching with bank, income and unemployment-benefit records.
- ODHS may give the information on this form to:
  - » Federal and state agencies who are doing reviews;
  - » Law enforcement officials, to help them arrest someone who is fleeing from the law;
  - » Federal and state agencies and private collection agencies, if I have to repay benefits to ODHS.
- ODHS will not use costs for shelter, medical, child care and court ordered child support to figure my food benefits if I do not report them.
- I follow the general work rules if I am told someone in my home is a work registrant.
- I understand I cannot get food benefits from the Tribal Food Distribution program and the SNAP program at the same time.
- Any person getting benefits in my group may lose food benefits if they quit a job or reduce work hours to less than 30 hours a week without a good reason.
- I agree to pay my copay in full each month.
- ***For day care (ERDC), I agree to report certain changes*** that affect anyone for whom I get benefits, including myself. I agree to report the following changes within 10-days for all members of my group:
  - » Address change;
  - » Household income is at or above the amounts shown in this table;
  - » Changing or adding a provider;
  - » Someone moves in or out, including a child, spouse or parent of an unborn child;
  - » Someone is no longer working due to job loss or medical leave;
  - » Someone on work search starts working;
  - » Someone returns to work after medical leave;
  - » Child care is needed while someone is attending school.
  - » A discharged military member returns to the household from active duty in a war zone.

Household size:	Gross monthly income:	
	ERDC	SNAP
1	-----	$1,473
2	$4,827	$1,984
3	$5,963	$2,495
4	$7,099	$3,007
5	$8,234	$3,518
6	$9,370	$4,029
7	$9,583	$4,541
8	$10,534	$5,052
Over 8	$10,534	+$512 each

- ***For food benefits (SNAP)***, I agree to report when the gross monthly income for my household is at or above the SNAP amounts in the table.
  - » The gross monthly income for my household is at or above the SNAP amounts in the table.
  - » Anyone in the household has lottery or gambling gross winnings of $4,250 or more;
  - » Any time an ABAWD's work hours (for pay, bartering or in-kind, or as a volunteer) go below 20 hours a week. This change must be reported within 10 days of the change.

Changes for Employment Related Day Care (ERDC) child care should be reported on the DHS 0862, *Change Report for ERDC*.

Changes for food benefits (SNAP) should be reported on the DHS 0853, *Simplified Reporting System* or DHS 0854, *Simplified Reporting System for Able-Bodied Adults without Dependents (ABAWD)*.

- I understand my answers on this form will affect my benefits. This information can cause my benefits to go up, down or stop. I will get a notice explaining how my answers on this form will affect my benefits and how to ask for a hearing.
- I will give proof of the information I have given ODHS. I will also let ODHS contact other people and agencies to get proof.
- For daycare benefits, I understand that I am required to pay my copay to my child care provider each month to continue to be eligible for the child care program.
- I understand the person who signs this form must repay benefits to ODHS when there is an overpayment in my case. The adults in the SNAP household during the time of the overpayment must also repay.
- I affirm under penalty of perjury that the statements made about persons in my home, income and all other information I have given ODHS are true and correct.

I understand that any child care benefits I receive will be reported to the Oregon Department of Revenue, which may affect my tax debt and/or potential return.

Full legal signature of applicant	Date
Full legal signature of other parent, spouse or other adult	Date

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Our non discrimination policy

The Oregon Department of Human Services (ODHS) does not discriminate against anyone. This means that ODHS will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs[1], disability or sexual orientation[2].

You may file a complaint if you believe ODHS treated you differently for any of these reasons.
To file a complaint with the state, you can call the Governor's Advocacy Office at 1-800-442-5238 (TTY 711) or write to their office at:

Governor's Advocacy Office
500 Summer Street NE, E17
Salem, OR 97301
Email: DHS.info@state.or.us

"Equal opportunity is the law!"

The United States Department of Agriculture (USDA) and the United States Health and Human Services (HHS) are equal opportunity providers and employers. Auxiliary aids and services are available upon request to individuals with disabilities.

To file a complaint with USDA and HHS, please read the "Client Discrimination Complaint Information" form (DHS 9001). You can find this form in the "Information and Referral Packet" (DHS 6609).

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[1]SNAP clients are protected against political belief discrimination.
[2]Sexual orientation is protected by the State of Oregon, but not federal laws.