



**OKLAHOMA DEPARTMENT OF HUMAN SERVICES**



Date: _____
Case name: _____
Case number: _____
County number: _____
Phone number: _____
Supervisor/worker number: __ / __

**Renew My Benefits**

Your worker 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.]

**1. Tell us about where you live.**

Mailing address		City	State	Zip
Finding address		City	State	Zip
Home phone	Work phone		Cell phone	
E-mail address			Message phone	

If your finding address is different from your mailing address, please give directions to your home: \_\_\_\_\_

**2. People getting benefits now.**

Our records show the people listed below are in your case and what benefits they are getting. Please mark yes or no in the last column if they are still living with you.

Name 1 <sup>st</sup> name MI	Num	Benefit	Benefit	Benefit	Does this person live with you?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

1 <sup>st</sup> name MI	Num	Benefit	Benefit	Benefit	Does this person live with you?
					<input type="checkbox"/> Yes <input type="checkbox"/> No

### 3. Tell us about other people living in your home.

Please fill out the information below for everyone else living in your home who is not already shown in number 2. If you want benefits for him or her, you must check the U.S. citizen block and fill in the Social Security number for each person. Your worker will contact you.

Name	Relationship to you	Date of birth	U.S. citizen	Social Security number (SSN)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

### 4. Tell us about your household's income for the month of \_\_\_\_\_.

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, unemployment benefits, military allotments, alimony, gambling winnings, Workers' Compensation, contributions, interest, dividends, pension, rental income, foster care or adoption subsidy payments, and income from mineral rights or oil and gas leases.

**If income has 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		

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Employer address		

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

Name of student	Full or part time?	Name of school

### 5. Tell us about your bills and expenses.

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

**A. Child care expense.**

How much do you pay each month for child care? \$ \_\_\_\_\_

Is your child care provider licensed in Oklahoma?  Yes  No

**B. Adult day care expense.**

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

**C. 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	Type of expense	Monthly expense
		\$
		\$
		\$

**D. 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?	To whom?	How much?	How often?
Street address	City	State	Zip
			Phone number

**E. Housing expenses.**

1. Do you get help to pay for housing?  Yes  No

If yes, who pays?	To whom?	How much? \$
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2. Do you or anyone in your household pay for housing? Yes  No
3. How much do you pay for housing? \$\_\_\_\_\_ per \_\_\_\_\_  
 Homeowner insurance, if separate: \$\_\_\_\_\_ per \_\_\_\_\_  
 Property tax, if separate: \$\_\_\_\_\_ per \_\_\_\_\_
4. Person or company you pay rent/mortgage to: \_\_\_\_\_  
 What is their phone number? (\_\_\_\_) \_\_\_\_\_
5. Do you expect to pay the same amount for housing next month?  Yes  No

**F. Utility expenses.**

1. Are you responsible for paying heating or cooling expenses? Yes  No
2. What utility expenses do you pay:  Phone  Electric  
 Gas/butane/propane  Wood  Garbage/water  
 Other \_\_\_\_\_

**6. 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  
 Individual retirement accounts (IRAs)  Mineral rights  Trust funds  
 Life insurance/burial policies  Land  Livestock  
 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

## 7. 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 company	
Address of insurance company		City	State	Zip
Policy holder name	Policy number		Relationship to insured	

### Health and dental screening:

People under age 21 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

## 8. Tell us about your need for child care.

Which children need child care?

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List the days and hours child care is needed:

First parent/caretaker Days and hours of work/school, including travel time	Second parent/caretaker Days and hours of work/school, including travel time

Who is your child care provider?

Name	Address	Area code	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:

\$ \_\_\_\_\_

Who is your emergency contact?	Phone
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## 9. Proof needed.

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

- receives food or child care benefits
- receives SoonerCare (Medicaid) and is disabled or age 65 or older.

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

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

If anyone:	then you must attach:
is working	<ul style="list-style-type: none"> <li>• pay stubs for all checks anyone got in the month of _____; or</li> <li>• statements from employers showing pay dates and earnings before taxes for the month of _____.</li> </ul>
has stopped working in the last five months	<ul style="list-style-type: none"> <li>• final pay check stub and employer's statement.</li> </ul>
is self-employed	<ul style="list-style-type: none"> <li>• a federal income tax return for the previous year; or</li> <li>• income and expense records if taxes have not been filed.</li> </ul>
gets unearned income	<ul style="list-style-type: none"> <li>• an award letter;</li> <li>• a letter from the person or agency who provides the income;</li> <li>• a check stub or copy of check; or</li> <li>• a court order.</li> </ul>
has stopped getting unearned income	<ul style="list-style-type: none"> <li>• a statement from the person or agency that gave you the income showing it has stopped.</li> </ul>
over age 60 or disabled has medical expenses not paid by insurance and wants food benefits	<ul style="list-style-type: none"> <li>• prescription printouts for the past 60 days;</li> <li>• insurance premium statements;</li> <li>• copy of doctor or hospital bills; and</li> <li>• statement of transportation costs.</li> </ul>
is paying court-ordered child support	<ul style="list-style-type: none"> <li>• court order, if not given to us before; and</li> <li>• proof of regular child support payments.</li> </ul>
has resources	<ul style="list-style-type: none"> <li>• checking and savings account statements or other financial statements for the month of _____;</li> <li>• copy of life insurance policy, if not given to us before;</li> <li>• copy of burial policy if not given to us before; or</li> <li>• copy of property deeds and titles, if not given to us before.</li> </ul>
has any vehicles, boats, RVs, or campers	<ul style="list-style-type: none"> <li>• proof of amount owed on loans.</li> </ul>
gets child care subsidy benefits	<ul style="list-style-type: none"> <li>• proof of your current work/school/training schedule.</li> </ul>

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

I understand that there are specific penalties for fraudulent activities, such as hiding information, making false statements, or the misuse of 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, Sections 2011 - 2036 of Title 7 of the United States Code. The information will be used to determine whether my household is eligible or continues to be eligible to participate in SNAP. OKDHS will verify this information through computer matching programs. 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 there is a food benefit overpayment, 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.
- I understand food benefits are prorated from the date of application.
- I understand that providing requested information, including the SSN of each household member, is voluntary. However, failure to provide this information will result in the denial of 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 could 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 review.

I understand that the SSN of persons included in the case will be 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 will be used to determine my eligibility for assistance.

I certify under penalty of perjury that I have 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 it is later determined I made a false claim of U.S. citizenship or lawful immigration status for anyone in my household, a complaint will be filed by OKDHS 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.

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Signature of client, guardian, conservator, or authorized representative	Date
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Use when client cannot read or write or signs by mark:

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Signature of witness	Date
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**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 your local OKDHS office by \_\_\_\_\_ or your benefits will stop on \_\_\_\_\_.