Lang's Application Assistance℠

Today's Date / Fecha de hoy

1. **Name Guardian / Nombre (Guardián(a)**
2. **Home Address / Dirección de Casa**
3. **County / Condado**
4. **Telephone Number / Número de Teléfono**
5. **Email / Correo Electrónico**

For official use only	
Gateway ID	
Case Number	
Client ID	
T Number	

Paid: $ _____

_____

Category of Assistance / *Categoría de Asistencia*

- ☐ Medicaid
- ☐ Food Stamps / Cupones de Alimento
- ☐ WIC
- ☐ Birth Certificate / Certificado de Nacimiento
- ☐ Passport / Pasaporte
- ☐ Social Security Card / Tarjeta de Seguro Social
- ☐ Immigration / Inmigracion
- ☐ Financial Assistance / Solicitud de Asistencia Financiera
- ☐ Other Services / Otro Servicios

☐ Corrections / Correcciones ☐ Renewal / Renovación

	Full Name *Nombre Completo*	**Birth Date** *Fecha de Nacimiento*	**Social Security Number** *Número de Seguro Social*
6.	Mother / Madre		
7.	Father / Padre		
8.	Child / Niño(a)		
9.	Child / Niño(a)		
10.	Child / Niño(a)		
11.	Child / Niño(a)		
12.	Child / Niño(a)		
13.	Child / Niño(a)		

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14.	Marital status / *Estado civil*	
◯ Single / Sotero(a)	◯ Divorced / Divorciado(a)	◯ Widowed / Viudo(a)
◯ Married / Casado(a)	◯ Seperated / Seperado(a)	

Pre-screening / Pre-evaluacion

Information about employment / *Informacion sobre empleo*

15. Who in the home is currently working? / *¿Quién en la casa está trabajando?*		
16. What is the name and phone number of the employer? / *¿Cual es el nombre y el número teléfono del empleador?*		
17. How much is the income? / *¿Cuánto es el ingreso?*		
$	☐ Weekly / Semanal ☐ Bi-Weekly / Quincenal	☐ Monthly / Mensual

Information about your household / *Informacion sobre su hogar*

18. Have you had food stamps previously? / *¿Ha recibido cupones de alimento anteriormente?*		
☐ Yes / *Sí*	☐ No / *No*	Year / *Año*
19. Does anyone have a disability? / *¿Alguien tiene una discapacidad?*		
☐ Yes / *Sí*	☐ No / *No*	
20. Do you have any unpaid medical bills? / *¿Tiene facturas médicas impagas?*		
☐ Yes / *Sí*	☐ No / *No*	
21. How much do you pay in rent or mortgage? / *¿Cuánto paga en alquiler o hipoteca?*		
☐ Rent / *Renta*	☐ Mortgage / *Hipoteca*	$
22. Do you pay for water, gas & light bills? / ¿Usted paga facturas de agua, gas & luz?		
☐ Yes / *Sí*	☐ No / *No*	
23. Do you pay for childcare? / ¿Usted paga por el cuidado de los niños?		
☐ Yes / *Sí*	☐ No / *No*	$

Appointment of Authorized Representative
(Competent Applicants Only)

I,_____,
Name (Parent/Guardian)

_____, residing at:_____
date of birth (Street, City, Zip)

hereby instruct/permit: Lang's Application Assistance (hereinafter "L.A.A."),

and/or

specifically: Antonio Lang to assist, represent, and act on my behalf for the purpose of obtaining Medicaid/SNAP/WIC Birth Certificate, and/or any other or governmental coverage or benefits for which I may be eligible under federal, state, or local laws (“collectively "benefits").

I AM SPECIFICALLY REQUESTING, THAT ANY FEDERAL, STATE OR LOCAL AGENCY OR DEPARTMENT ("AGENCY") ADMINISTERING ANY BENEFITS ALLOW THE ABOVE-NAMED INDIVIDUAL, OR ORGANIZATION, TO:

Help me in identifying and understanding specific Benefits for which I may be eligible.

Assist me in completing and filing, in paper form or electronically, any form or application required to obtain any Benefits, which may include submission of an application or other required information to an Agency through one or more website or other electronic portals maintained by an Agency or other third parties.

Obtain and submit to the Agency, any documents or verifications required to establish eligibility for any Benefits.

Assist in initiating any hearing, litigation, or other administrative process on my behalf, to establish eligibility or otherwise preserve my rights. This includes arranging transportation as needed and accompanying or representing me at interviews and administrative hearings.

Obtain information from any Agency (including but not limited to any welfare office, state department of social services, state disability evaluation division or any other federal, state, or local equivalent to any of the foregoing) regarding the status of my application.

Review my case file, with or without my attendance, to the fullest extent permitted with this consent by federal, state, and local rules, regulations, and statutes.

Receive a copy of any specific Notice of Action (NOA) or any other notices intended for me or my representative, from the Welfare office or any other Agency. I hereby request that the Welfare office (or any other Agency as applicable) provide the authorized representative identified above with a copy of any ***denial*** NOA (or any similar notice) issued on my application.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

Abide by all applicable federal, state, and local laws, rules, and regulations with respect to the Medicaid/SNAP WIC & Birth Cert application process and any other application of Benefits to any other Agency. **This includes, but is not limited to, any specific actions which under such rules can be performed only by me and cannot be delegated to my authorized representative.**

Provide all information required to verify any application for benefits before any agency issues a final determination of my eligibility for Benefits.

Provide truthful, complete, and accurate information, to the best of my knowledge, on any application or other disclosure that will be submitted to any Agency. I understand that L.A.A. does not independently verify or warrant the accuracy or completeness of any information I provide, and that any fraudulent activities in connection with any benefits or any failure to provide complete and accurate information to any agency could give rise to criminal or civil penalties against me. Furthermore, I recognize that my full participation and cooperation are needed to successfully complete an application for benefits or any other aspect of this process. Lastly, I will cooperate fully with any governmental investigation related to activities pursuant to this appointment, including but not limited to claims of fraud, misconduct, or

Appointment of Authorized Representative
(Competent Applicants Only)

false statements on an application for benefits.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

Change or revoke this instruction/permission at any time. Revocation may be via verbal or written communication to the agency and will be effective immediately. I further acknowledge the authorized representative's right to discontinue activity on my behalf, at any time and for any reason, by providing written notice to myself and the agency handling my application.

Seek independent counsel at any time.

WAIVER OF CONFLICT OF INTEREST: I understand that L.A.A is acting as an agent for the community providing me assistance and do hereby waive any potential conflict of interest.

CONFIDENTIALITY: All information received from or about me during representation will be maintained as confidential except as required to establish or confirm eligibility for Benefits, or as otherwise required by law.

TIME LIMIT: Unless otherwise allowed by State or local rules and regulations or earlier revoked, this authorization will remain in full force and effect for 12 months from the date signed below, unless another date or event is listed. Date:

REQUIRED STATEMENTS: I understand that the information provided based on this Authorization may be disclosed to another party by the authorized recipient, and that neither the Department of Health and Human Services nor any other agency has any control over any additional disclosure and cannot protect the information after it is released based on this authorization.

By signing this legal document, I have read and understand this agreement in its entirety.

Signed: _____ Date: _____

(Applicant/Responsible Relative/Conservator)

Signed: _____ Date: _____

(Authorized Representative)