

Application



Washington County Community Action Council

117 Summit Avenue, Hagerstown, MD 21740

Phone: 301-797-4161

Website: www.wccac.org

WCCAC SNAP APPLICATION

Date

Head of Household Name

Date of Birth

Social Security Number

E-mail

Phone Number

Preferred Contact Method

Street Address

City

State

Zip

Select one that applies

☐ Renter

☐ Homeowner

☐ Homeless

☐ Other

1. Is anyone in your household receiving benefits under another identity or as a member of another household or in another State?

☐ Yes ☐ No

2. Has anyone in your household been convicted since August 22, 1996 in a federal or state court for not telling the truth about where they lived or their identity in order to receive food supplement benefits or cash assistance from more than one place in the same month?

☐ Yes ☐ No

3. Has a court convicted any member of your household for trading or trafficking SNAP benefits of \$500 or more?

☐ Yes ☐ No

4. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?

☐ Yes ☐ No

5. Has anyone in your household been convicted of a drug kingpin felony on or after August 22, 1996?

☐ Yes ☐ No

6. Has anyone in your household been convicted of a volume dealer drug felony on or after August 22, 1996?

☐ Yes ☐ No

7. Has anyone in your household been convicted after February 7, 2014 of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, sexual assault*, or a similar state law, and is also not in compliance with the terms of their sentence?

☐ Yes ☐ No

In spaces below, please fill in ALL household members. List yourself first.

Please use the following choices for "RACE":

- | | |
|-----------------------------------|-------------------------------------|
| 1. American Indian/Alaskan Native | 5. Native Hawaiian/Pacific Islander |
| 2. Asian | 6. Other |
| 3. Black/African American | 7. White |
| 4. Multi-Race | |

Please use the following for "GENDER":

- | | |
|--------------------------|---------------------------|
| 1. Transgender FTM | 5. Other (Male or Female) |
| 2. Transgender MTF | 6. Transgender |
| 3. Gender Non-Conforming | |
| 4. Non-binary | |

First & Last Name	Date of Birth	Relationship to Applicant	Sex	Gender Code
Social Security Number	Race Code	Hispanic/Latino	Marital Status	
Disabled	Citizen	Veteran	Pregnant	Enrolled in School
Health Insurance	Registered to Vote			

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Income & Expenses

DECLARATION OF HOUSEHOLD INCOME

Below please report GROSS income for the entire household (Amounts before taxes and insurance)

Household Member Name	Type of Income	Employer	Gross Amount per Month

Total Household Income for last 30 days

MONTHLY EXPENSES:

Provide the amount (\$) below and specify which household member(s) pays for each expense.

	Mortgate/Rent	Rental/Homeowners Insurance	Property Taxes	Phone	
Amount					
Who Pays					
	Cable/WiFi	Water/Sewage	Gas and Electric	Oil	Other
Amount					
Who Pays					
	Total Monthly Expenses				

Terms

Grievance Process

If a client wishes to file a grievance, they may submit it in writing to CAC's Chief Executive Officer (CEO), describing the situation and their concerns. Within fourteen (14) days of receiving the written grievance, the CEO or designee will arrange a meeting with the client to discuss the grievance and work toward a resolution. Clients may file a grievance without fear of retaliation.

☐ I acknowledge that I have read and understand the information regarding the Grievance Process described above.

USDA Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of 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.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain 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**.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling **(833) 620-1071**, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

mail:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

fax:

(833) 256-1665 or (202) 690-7442; or

email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Consent Form



Wes Moore, Governor • Aruna Miller, Lt. Governor • Rafael López, Secretary

SNAP OUTREACH PROGRAM CONSENT FOR RELEASE OF INFORMATION

This form authorizes information to be released from the Local Department of Social Services to the Community Based Organization and Customer.

I authorize the Family Investment Administration to release all information contained in, and concerning the status of, my application/redetermination for Public benefits, as a resident of the State of Maryland, to the following agency:

Washington County Community Action Council
Name of Community Based Organization

117 Summit Avenue, Hagerstown MD 21740
Address

This information may be released to the following person (s):

Sierra Romero
Name

SNAP Coordinator
Staff Position

sromero@wccac.org
Email

(301) 797-4161
Phone

Elise Johnson
Name

Program Director
Supervisor /Position Title

ejohnson@wccac.org
Email

(301) 797-4161
Phone

☐ I acknowledge that I have read, understand and agree to the Consent Release statement described above.

Name of applicant/recipient

Date of Birth

or Social Security Number

Signature of applicant/recipient or authorized representative

Date Signed

This form is valid for 12 months from the date of signature. Note: this consent may be revoked by the customer, in writing, at any time except to the extent that action has been taken in reliance upon it.

25 S. Charles Street, Baltimore, MD 21201- 3330
Tel: 1-800-332-6347 | TTY: 1-800-735-2258 | www.dhs.maryland.gov