

Emergency Assistance for Families Application

PLEASE NOTE: If you need cash assistance, health care, or Supplemental Nutrition Assistance Program (SNAP) benefits, you must complete the Pennsylvania Application for Benefits (PA 600).

This is an application for cash benefits. If you need this application in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Esta es una solicitud de beneficios de asistencia monetaria. Si necesita esta solicitud en otro idioma o alguien para que interprete, comuníquese con la oficina de asistencia de su condado. La ayuda bilingüe será gratuita.

这是一份现金福利申请表。如果您需要其他语言版本的申请表或需要人员翻译该申请表，请联系当地的县援助办公室。您将免费获得语言协助。

Đây là đơn xin hưởng các khoản tiền phúc lợi. Nếu bạn cần đơn này bằng ngôn ngữ khác hay cần người dịch thì vui lòng liên hệ với văn phòng hỗ trợ quận tại địa phương mình. Hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí.

នេះគឺជាពាក្យសុំស្នើសុំអត្ថប្រយោជន៍ជាសាធារណៈ ។ ប្រសិនបើអ្នកត្រូវការដាក់ពាក្យជាភាសាផ្សេងៗ ឬអ្នកប្រកបរបរ សូមទាក់ទងការិយាល័យជំនួយខោនធីរបស់អ្នក ។ អ្នកនឹងទទួលបានជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ ។

هذا تطبيق مخصص للمستحقات النقدية. إذا كنت تريد تصفح هذا التطبيق بلغة أخرى أو كنت تريد مترجماً، فالرجاء الاتصال بمكتب المساعدة المحلي التابع للمقاطعة الخاصة بك. وسيتم توفير المساعدة اللغوية مجاناً.

В этом приложении будут содержаться все данные о ваших денежных пособиях. Если вы хотите переключить язык приложения или вам требуются услуги перевода, обратитесь в окружное отделение социальной помощи. Такие услуги предоставляются бесплатно.

Instructions:

Please read the entire form.

If you need help, another person can help you or you can get help from your county assistance office.

Please review all questions and provide a response unless the instructions tell you that you can choose not to answer.

You or any representative you choose may complete this application. Your representative can be your spouse, a friend, a relative, or a person who has your power of attorney. It should be someone who knows and can provide information about your income and resources.

After the form is completed, mail it to the county assistance office unless instructed otherwise.

You will need proof of identity and verification for other information on the form unless we already have the information in our records.

If you need help to obtain any information, ask your county assistance office for help. You should attach verification to this form.

1. Do you have a child under the age of 18 who is related to you and living in your household or are you pregnant?
2. Were you actively employed as of March 11, 2020 and experienced a temporary loss of income or a reduction of hours by at least 50% due to COVID-19?
3. Are your current available resources in checking and/or savings less than \$1,000.00?
4. Are you able to verify your loss or reduction of employment through paystubs or employer letter?
5. Are you able to verify your available resources account balance?

If you have a disability and need this application in large print or another format, please call our helpline at **1-800-692-7462**.

Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing **711**.

CAO Use Only					
APPLICATION REGISTRATION NUMBER	CASELOAD	COUNTY	DISTRICT	RECORD NUMBER	DATE STAMP

If you or your children are or have been victims of domestic violence, or are at risk of further violence, you can find more information about crisis intervention, counseling, accompaniment to police, medical, and court facilities, temporary emergency shelter, and prevention and education programs, by calling:

The Pennsylvania Coalition Against Domestic Violence
1-800-932-4632 (in PA) 303-839-1852 (National)

Questions?

Call your county assistance office or our CUSTOMER SERVICE CENTER at **1-877-395-8930**.
In Philadelphia, call **1-215-560-7226**.

We are here to help you. Call Monday thru Friday 8:30 a.m. to 5 p.m.
TDD Services are available by calling PA Relay Services at **711**.



COMPASS
CLICK. APPLY. BENEFIT.

You can apply online at: www.compass.state.pa.us.

I understand that I am applying for Emergency Assistance. The application is a result of a temporary loss of income or a reduction of hours by at least 50% due to the Coronavirus (COVID 19) emergency.

I understand that in order to apply for this assistance,

- I must have a child under the age of 18 or I must be pregnant (pregnancy verification must be provided if no child in household is under age 18).
- I must have been employed as of March 11, 2020, and I must have experienced at least a 50% reduction of hours or loss of employment.
- I must provide verification of available resources (checking and/or savings accounts). Verification of resources includes but is not limited to bank statements.
- I must provide verification of temporary reduction in employment hours or temporary loss of employment. Verification of employment or reduction of hours includes but is not limited to pay stubs, statement from employer, or unemployment compensation letter. Pay stubs used to verify reduction must include 2 weeks of income prior to the reduction.
- Self-employment may be verified by providing a present tax return or other self-employment documentation which reflects a reduction or loss of income.
- I understand this application may be denied if I do not submit valid verifications and/or the county assistance office is unable to obtain verification of my information.

Tell us about you, the applicant: We may need to contact you.

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)			Social Security number:		
Home address (Include street, apt. number, city, state & ZIP code+4)					
Birthdate (MM/DD/YYYY):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's license or state ID number if you have one:	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married
Phone number: ()	Phone type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Second phone number: ()	Phone type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, due date?		Are you a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you are not a U.S. citizen or national, answer the following questions:	Do you have eligible immigration status? <input type="checkbox"/> Yes		If yes, fill in the document type and ID number:	Document type:	Document ID number:
RACE (Optional) (Check all that apply)	<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other _____	
ETHNICITY (Optional)	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino				

Sign here:

X

Your signature or your representative's signature

Date

Tell us about people in your home:

We need to gather information about everyone who lives at your address, even if they are not applying for benefits.

Note: You do not need to file a tax return to get benefits.

Person 2

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)				Social Security number:		Are you applying for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's license or state ID number if this person has one:	Marital Status ▶	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married	
How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Not Related <input type="checkbox"/> Other _____				Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this person pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, due date?		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are not a U.S. citizen or national, answer the following questions:		Does this person have eligible immigration status? <input type="checkbox"/> Yes		If yes, fill in the document type and ID number:		Document ID number:	
RACE (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other _____	
ETHNICITY (Optional)		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino					

Person 3

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)				Social Security number:		Are you applying for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's license or state ID number if this person has one:	Marital Status ▶	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married	
How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Not Related <input type="checkbox"/> Other _____				Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this person pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, due date?		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are not a U.S. citizen or national, answer the following questions:		Does this person have eligible immigration status? <input type="checkbox"/> Yes		If yes, fill in the document type and ID number:		Document ID number:	
RACE (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other _____	
ETHNICITY (Optional)		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino					

Person 4

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)				Social Security number:		Are you applying for this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver's license or state ID number if this person has one:	Marital Status ▶	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married	
How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Not Related <input type="checkbox"/> Other _____				Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this person pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, due date?		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are not a U.S. citizen or national, answer the following questions:		Does this person have eligible immigration status? <input type="checkbox"/> Yes		If yes, fill in the document type and ID number:		Document ID number:	
RACE (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other _____	
ETHNICITY (Optional)		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino					

Persons 5 and up: Please attach additional sheets as necessary.

Resources:

Please tell us about resources, such as: • Savings account(s) • Checking account(s)

List each resource separately:

Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
	<input type="checkbox"/> Savings account <input type="checkbox"/> Checking account		
	<input type="checkbox"/> Savings account <input type="checkbox"/> Checking account		
	<input type="checkbox"/> Savings account <input type="checkbox"/> Checking account		
	<input type="checkbox"/> Savings account <input type="checkbox"/> Checking account		

Employment or Other Income:

Was someone in this household employed as of March 11, 2020?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?	Employer:	Date:
Has anyone stopped working or had a reduction of hours by at least 50% since March 11, 2020?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?	Employer:	Date:
Was the reduction in hours or loss of employment due to COVID 19? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has anyone applied for and/or is receiving Unemployment Compensation, Supplemental Security Income, Retirement, Survivors, and Disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Criminal history inquiry:

Please answer the following questions for yourself and anyone else for whom you are applying:

Does anyone have a summons or warrant to appear as a defendant at a criminal court proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
Does anyone owe fines, costs or restitution for a felony or misdemeanor offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

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

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

<input type="checkbox"/> Given to Client __/__/__	<input type="checkbox"/> Sent to voter registration __/__/__	<input type="checkbox"/> Mailed to Client __/__/__
<input type="checkbox"/> Declined, not interested __/__/__	<input type="checkbox"/> Not a U.S. citizen __/__/__	<input type="checkbox"/> Declined, already registered __/__/__

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

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.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), 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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (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: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred (\$100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days (90 days for Supplemental Nutrition Assistance Program (SNAP) benefits) from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. An alien who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S.C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

PRIVACY ACT STATEMENT

(i) The collection of this information, including the Social Security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) 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.

(iii) If a SNAP claim arises against your household, 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.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
 - I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the insurance department or the CHIP contractor.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

(Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

X

Signature of Applicant or Authorized Representative

Date

Name of Authorized Representative	Address of Authorized Representative	Phone Number

**COUNTY
ASSISTANCE
OFFICE ONLY**

I have explained to the applicant her or his rights and responsibilities.

CAO Signature

Date

Prohibitions and Penalties Read about your responsibilities:

IF THIS HAPPENS WITHOUT GOOD CAUSE		THIS MAY HAPPEN (PENALTY)
CASH	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.	Fine, prison, or both.
	On purpose, give information that is false, incorrect or incomplete, or not report changes.	Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings. Not eligible for cash: • First time - 6 months. • Second time - 12 months. • Third time - forever.
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.	Not eligible: • All court convictions - 12 months.
	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.	Not eligible until you comply with your penalty.
	Lie about where you live to receive cash in two or more states.	Not eligible for 10 years.
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.	Not eligible until you do what the law says.
If you are found guilty of fraud or breaking the above rules:		<ul style="list-style-type: none"> • Fine up to \$15,000; • Jail up to seven years; and/or • Paying back benefits received. • Disqualification from benefits for periods stated above by program.

The Pennsylvania Department of Human Services (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, gender, gender identity or expression, or sexual orientation.

DHS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact your local county assistance office.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Bureau of Equal Opportunity, Room 223, Health and Welfare Building, P.O. Box 2675, Harrisburg, PA 17105-2675, (717) 787-1127, PA Relay Services 711, Fax (717) 772-4366, or Email - RA-PWBEOAO@pa.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Your Rights and Responsibilities

Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

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.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (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: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred (\$100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days (90 days for Supplemental Nutrition Assistance Program (SNAP) benefits) from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. An alien who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S.C 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

PRIVACY ACT STATEMENT

(i) The collection of this information, including the Social Security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) 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.

(iii) If a SNAP claim arises against your household, 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.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
 - I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.

- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the insurance department or the CHIP contractor.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

(Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice contains important information about the privacy of your medical information. If you need this notice in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Este aviso contiene información importante acerca de la privacidad de su información médica. Si necesita este aviso en otro idioma o alguien para que interprete, comuníquese con la Oficina de Asistencia de su Condado. La asistencia bilingüe será gratuita.

Данное уведомление содержит важные сведения относительно конфиденциальности вашей медицинской информации. Если вам нужно данное уведомление на другом языке или вам нужны услуги устного переводчика, обращайтесь в Бюро помощи вашего округа (County Assistance Office). Переводческие услуги предоставляются бесплатно.

此通知包括关于您的医疗信息的个人隐私方面的重要资料。如果您需要此通知译成其它语言或需要有人替您翻译，请联系您所在地区的郡县援助办事处。可提供免费语言协助。

Thông báo này gồm những thông tin quan trọng về việc bảo mật các chi tiết y tế cá nhân của quý vị. Nếu cần có thông báo này bằng một ngôn ngữ khác hay người để thông dịch, xin quý vị liên lạc với Văn Phòng Trợ Cấp Địa Phương. Trợ giúp ngôn ngữ sẽ được cung cấp miễn phí.

សំបុត្រនេះមានព័ត៌មានសំខាន់ៗអំពីការអភិរក្សភាពសម្ងាត់ព័ត៌មានពេទ្យរបស់លោកអ្នក។ បើលោកអ្នកត្រូវការសំបុត្រនេះ ជាភាសាផ្សេងទៀត ឬត្រូវការអ្នកបកប្រែសំបុត្រក៏ដូចជា ប្រសិនបើលោកអ្នកមិនអាចអានសំបុត្រនេះបាន ក៏សូមទាក់ទងការណ៍យើងដើម្បីរៀបរាប់សំណើអ្នក។ ព័ត៌មានទាំងនេះអាចត្រូវបានផ្តល់ជូនដោយឥតគិតថ្លៃ។

يحتوي هذا الإخطار على معلومات هامة حول خصوصية المعلومات الطبية المتعلقة بك. إذا كنت بحاجة إلى هذا الإخطار بلغة أخرى أو إلى شخص ما لترجمته لك، فيرجى الاتصال بمكتب معونة المقاطعة المحلي. وستقدم المساعدة اللغوية مجاناً.

The Department of Human Services (DHS) provides and pays for many types of benefits and social services. We also determine an individual's eligibility to receive benefits and services. To do these things, we have to collect personal and health information about you and/or your family. The information we collect about you and/or your family is private. We call this information “protected health information.”

DHS does not use or disclose DHS health information unless it is permitted or required by law. DHS is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices concerning protected health information and to notify affected individuals in the case of a breach of unsecured protected health information. As a “covered entity,” DHS must follow applicable laws protecting the privacy of your protected health information which include the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. Under HIPAA, Medicaid agencies, certain health plans and health care providers are examples of covered entities that must comply with HIPAA. Other laws that may apply include rules concerning confidential information about Medical Assistance, other benefits, behavioral health, substance abuse/treatment and HIV/AIDS. When we use or disclose protected health information, we make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose. This notice explains your right to privacy of your protected health information and how we may use and disclose that information. For more information on DHS privacy practices, or to receive another copy of this notice, please contact us. For information on how to contact us, see the “Questions or Complaints” section on the last page of this notice.

We are required by law to follow the terms of this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. If we make an important change in our privacy policies or procedures, we will post a revised copy of the notice on our website and/or provide you with a new privacy notice by mail or in person. You may request and receive a paper copy of this notice at any time.

What is protected health information?

Protected health information is information about you that relates to a past, present or future physical or mental health condition, treatment or payment for treatment, and that can be used to identify you. This information includes any information, whether verbal or recorded in any form, that is created or received by DHS or persons or organizations that contract with DHS. This includes electronic information and information in any other form or medium that could identify you, for example:

Your name (or names of your children)
Address
Date of birth
Admission/discharge date
Diagnostic code

Telephone number
DHS case number
Social Security number
Medical procedure code

Who sees and shares my health information?

DHS professionals (such as caseworkers and other county assistance office and program staff) and people outside of DHS (such as our contractors, health maintenance organization (HMO) staff, nurses, doctors, therapists, social workers and administrators) may see and use your health information to determine your eligibility for benefits, treatment, payment or for other required or permitted reasons. Sharing your health information may relate to services and benefits you had before, receive now, or may receive later. DHS will not use or share genetic information about you when deciding if you are eligible for Medicaid.

Why is my protected health information used and disclosed by DHS?

There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described below.

For Treatment: We may use or disclose information so that you can receive medical treatment or services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care.

For Payment: We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services.

For Operating Our Programs: We may use or disclose information in the course of our ordinary business as we manage our various programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you and/or your family.

For Public Health Activities: We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer.

For Law Enforcement Purposes and As Required by Legal Proceedings: We will disclose information to the police or other law enforcement authorities as required by court order.

For Government Programs: We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program.

For National Security: We may disclose information requested by the federal government when they are investigating something important to protect our country.

For Public Health and Safety: We may disclose information to prevent serious threats to health or safety of a person or the public.

For Research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.

For Coroners, Funeral Directors and Organ Donation: We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties.

For Reasons Otherwise Required By Law: DHS may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

Do other laws also protect certain health information about me?

DHS also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you. For example, if we have HIV or substance abuse information, with a few exceptions, we may not release it without special, signed written permission that complies with the law. In some situations, the law also requires us to obtain written permission before we use or release information concerning mental health or intellectual disabilities and certain other information.

Can I ask DHS to use or disclose my health information?

Sometimes, you may need or want to have your protected health information sent or otherwise disclosed to someone or somewhere for reasons other than treatment, payment, operating our programs, or other permitted or required purpose not needing your written authorization. If so, you may be asked to sign an authorization form, allowing us to send or otherwise disclose your protected health care information as you request.

The authorization form tells us what, where and to whom the information will be sent or otherwise disclosed. You may revoke your authorization or limit the amount of information to be disclosed at any time by letting us know in writing, except to the extent that DHS has already taken action in reliance upon the authorization.

If you are younger than 18 years old and, by law, you are able to consent for your own health care, then you will have control of that health information. You may ask to have your health information sent to any person who is helping you with your health care.

Except as described in this Notice, we will not use or disclose your health information without your written authorization. For example, HIPAA generally requires written authorization before a covered entity may use or disclose an individual's psychotherapy notes. In most cases, HIPAA also requires written authorization before a covered entity may use or disclose protected health information for marketing purposes or before it sells it.

What are my rights regarding my health information?

As a DHS client, you have the following rights regarding your protected health information that we use and disclose:

Right to See and Copy Your Health Information: You have the right to see most of your protected health information and to receive a copy of it. If you want copies of information you have a right to see, you may be charged a small fee. However, generally, you may not see or receive a copy of: (1) psychotherapy notes; or (2) information that may not be released to you under federal law.

If we deny your request for protected health information, we will provide you a written explanation for the denial and your rights regarding the denial.

DHS does not receive or keep a file of all of your protected health information. Doctors, hospitals, nursing homes and other health care providers (including an HMO, if you are enrolled in one) may also have your protected health information. You also have a right to your health information through your doctor or other provider who has these records.

Right to Correct or Add Information: If you think some of the protected health information we have is wrong, you may ask us in writing to correct or add new information. You may ask us to send the corrected or new information to others who have received your health information from us. In certain cases, we may deny your request to correct or add information. If we deny your request, we will provide you a written explanation of why we denied your request. We will also explain what you can do if you disagree with our decision.

Right to Receive a List of Disclosures: You have the right to receive a list of where your protected health information has been sent, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list. For example, the law does not require us to add to the list any disclosures we may have made to you, to family or persons involved in your care, to others you have authorized us to disclose to, or for information disclosed before April 14, 2003.

Right to Request Restrictions on Use and Disclosure: You have the right to ask us to restrict the use and disclosure of your protected health information. We may not be able to agree to your request. In fact, in some situations, we are not permitted to restrict the use or disclosure of the information. If we cannot comply with your request, we will tell you why. Except as otherwise required by law, we must grant your request to restrict disclosure to a health plan if the purpose of disclosure is not for treatment and the medical services to which the request applies have been paid out-of-pocket in full.

Right to Request Confidential Communication: You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.

Right to Receive Notification of a Breach: You have the right to receive notification if there is a breach of your unsecured protected health information

Whom do I contact about my rights or to ask questions about this notice?

You can contact the DHS HIPAA helpline, toll-free at 800-692-7462 to discuss your rights or to ask questions about this notice. You can also contact your caseworker or health care provider or write to DHS's Privacy Office, 3rd Floor West, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120.

You can receive important information or updates to this notice by visiting DHS's Web site at www.dhs.pa.gov.

How do I file a complaint?

You may contact either office listed below if you want to file a complaint about how DHS has used or disclosed information about you. There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. DHS and its employees and contractors cannot and will not retaliate against you for filing a complaint.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES PRIVACY OFFICE
3RD FLOOR WEST, HEALTH AND WELFARE BUILDING
7TH AND FORSTER STREETS
HARRISBURG, PA 17120

REGION III
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
150 S. INDEPENDENCE MALL WEST - SUITE 372
PHILADELPHIA, PA 19106-9111

Effective: April, 2003 – Revised July 28, 2015



pennsylvania
DEPARTMENT OF HUMAN SERVICES

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-692-7462 (TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-692-7462 (TDD: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-692-7462 (TDD: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вы можете воспользоваться бесплатными услугами перевода. Звоните 1-800-692-7462 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-692-7462 (TDD: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។
ចូរ ទូរស័ព្ទ 1-800-692-7462 (TTY: 711)

ملحوظة: إذا كنت تتحدث لغة أخرى، فسوف تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل برقم 1-800-692-7462 (رقم هاتف الصم والبكم: 711)

주: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-692-7462 (TDD: 711) 번으로 전화해 주십시오.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-692-7462 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-692-7462 (ATS : 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-692-7462 (TDD: 711).

লক্ষ্য করুন: আপনি যদি বাংলায় কথা বলতে পারেন, তাহলে আপনি বিনা খরচে ভাষা সহায়তা পরিষেবা নিতে পারেন। 1-800-692-7462- নম্বরে কল করুন (TTY: 711)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-692-7462 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-692-7462 (TDD: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-692-7462 (TDD: 711).

ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने भाषा सहायता सेवाहरू तपाईंको लागि नि:शुल्क रूपमा उपलब्ध छन्। 1-800-692-7462 (TDD: 711) मा फोन गर्नुहोस्।



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