TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS/ELIGIBILITY STAFF

FROM: KEVIN MAHON, EXECUTIVE DIRECTOR, FIA

RE: PURCHASE OF CHILD CARE AND FAMILY INVESTMENT FORMS CONSOLIDATION

PROGRAMS AFFECTED: TEMPORARY CASH ASSISTANCE AND PURCHASE OF CARE

ORIGINATING OFFICE: OPA/ DIVISION OF PROGRAM POLICY AND REGULATION

BACKGROUND:

The responsibility of determining eligibility for the Purchase of Care Program has been transferred to the Family Investment Administration. It became apparent that there was a need to merge the forms used by the FIA workers to enable them to accomplish the additional tasks. Attached are draft forms modifications designed by the POC/FIA Forms Consolidation Workgroup.

ACTION REQUIRED:

The Purchase of Care application will be used as an extra page of the Combined Application (CAF) in all non-CARES jurisdictions other than Baltimore City. Additionally the first three pages of the CAF have been modified to include the POC program. The POC application will be used as an addendum page to the Assistance Request Form (ARF) in CARES jurisdictions. Baltimore City has developed its own version of the POC/CAF modifications to fit their particular Purchase of Care process. Modifications have been made to the 903 Assignment of Support Rights to include the Purchase of Care Program. The revised Child Support form can be used statewide.

ACTION DUE DATE: Local departments may implement the use of the consolidated forms as soon as they are printed and supplies are received.

ACTION REQUIRED OF: All Local Departments of Social Services
EFFECTIVE DATE: October 1, 1996

For questions call Patricia Jeffers at 767-7143 or the DHR Help Desk at (410) 767-7002 or 1-800-347-1350.

PGJ/pgj
Attachments

cc:   DHR Executive Staff
      FIA Management Staff
      CCA Management Staff
      CSEA Management Staff
MARYLAND DEPARTMENT OF HUMAN RESOURCES
INCOME MAINTENANCE ADMINISTRATION COMBINED APPLICATION

INTENT TO FILE

Appointment Date: _______________ Time: _______________ LDSS Representative: _______________ Date: _______________

STEP 1: To begin to apply and establish your application date, you can complete this first page, tear it off and give it to us today. We are required to verify information you provide and to take action on your application within 30 days from the date you give us this completed first page. Benefits must be provided from the date you gave us this first page. The sooner you give us this first page and any required verification, the quicker you will know whether you will receive benefits. The case worker will tell you what information needs to be verified and the items to bring for your interview. You must provide the rest of the application before an eligibility decision can be made (usually within 30 days of the application date). If you qualify to get food stamps right away, we are required to take action on your application within 5 days from the date you gave us this completed first page.

Your Name: ___________________________ Last Name: ___________________________ First: ___________________________ MI: ___________________________ Maiden/Other: ___________________________ Telephone number where you can be reached: ___________________________

Mailing Address: ___________________________ City: ___________________________ State: ___________________________ Zip Code: ___________________________

Social Security Number: ___________________________ Date of Birth: ___________________________ Race: ___________________________ Sex: ___________________________

Sign here: ___________________________ Today's date: ___________________________

ARE YOU A BOARDER? ☐ Yes ☐ No IS ANYONE IN YOUR HOUSEHOLD ON STRIKE? ☐ Yes ☐ No

WHAT TYPE(S) OF HELP ARE YOU APPLYING FOR? ☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Day Care (POC)

DO YOU HAVE CHILDREN UNDER AGE 18 LIVING WITH YOU? ☐ Yes ☐ No

COMPLETE OTHER SIDE
Mandatory Documentation

Submission of a Social Security Number (SSN) is mandatory for you and all members of your household. SSN, as well as other information provided, will also be used in computer matching and program review or audits to make sure your household is eligible for Federal assistance programs, Federally assisted State programs and State only programs, such as school lunch, General Public Assistance and Medicaid. This may involve our contacting your employer, bank or other party. Fraudulent participation in the Food Stamp, Public Assistance and Medical Assistance programs may result in criminal or civil action or administrative claims.

For each person who is not a U.S. citizen you will need to show the Social Services Office either documentation from the Immigration and Naturalization Service (INS) or other documents the State agency determines are proof of your immigration status. Alien status is subject to verification with INS which may require submission of certain information from this application form to INS. Information received from INS may affect your household’s eligibility and level of benefits. Each household member must certify that he or she is a U.S. citizen or is living in the U.S. in lawful immigration status.

Applicant – To begin to apply for assistance, complete the entire application, answering all questions to the best of your ability. The application will be reviewed during your interview. If you need additional help, the agency will help you.

1. What type(s) of help are you applying for? ☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Day Care (POC)
2. Why are you applying? ☐ Illness or disability ☐ Pregnancy ☐ Age ☐ Unemployment ☐ Broken Marriage ☐ Other
3. Do you have any of these problems? ☐ Fuel or power cut-off ☐ Eviction ☐ No food
☐ No place to stay ☐ Medical problems ☐ Medical bills in the last 3 months. ☐ Not Applicable
4. Do you need help with child care while you are away from home? ☐ Yes ☐ No ☐ Not Applicable
5. Is there a minor living with you who is a parent or an expectant parent? ☐ Yes ☐ No
6. Does anyone in your household need help because of problems with drugs or drinking? ☐ Yes ☐ No

Your Name
Last
First
MI Maiden/Other
Marital Status
Telephone number where you can be reached

Your Address (where you live) Street
City State Zip Code For how long?

Your mailing address (if different)
City State Zip Code

Your Former Address (if at present address less than 1 year)

Your Spouse’s Last Name, if living with you
First
M.I. Maiden/Other Name

CA 2
### Household members older than 13 years of Age

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Race</th>
<th>Sex</th>
<th>Relationship to you</th>
<th>Name of school or employer</th>
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</table>

### Income Information

Complete those that apply for household members:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount (per)</th>
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</thead>
<tbody>
<tr>
<td>Gross Salary</td>
<td>$</td>
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<tr>
<td>AFDC</td>
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<tr>
<td>Child Support</td>
<td>$</td>
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<tr>
<td>Other</td>
<td>$</td>
</tr>
</tbody>
</table>

Attach proof of all income for applicant, spouse, other parent in home, parents of teen parent, adult and spouse with physical custody of teen parent.

### Child Support Information

**BE SURE TO CHECK 903**

- Are you getting child support for all children in your household who are eligible for child support?  
  - Yes  
  - No

- Have you applied for child support for all children in your household eligible to receive child support?  
  - Yes  
  - No

- Do you claim good cause for not pursuing child support for any child in your household eligible for child support?  
  - Yes  
  - No

If you claim good cause, you are required to give proof of your claim. The POC worker will send you information and a form to help you with your claim.

Your application gives us information about whether you are eligible for benefits and services. Public money pays for the benefits. You must give true information. Information you give may be checked with public and private agencies and businesses. There are penalties for giving false information. Maryland law states that it is a misdemeanor to get fraudulently, or try to get, public aid. This means deliberately saying something false or pretending to be someone else. It also includes not reporting changes in household or income. Punishment for this is repayment, a fine of up to $1,000, and a possible prison sentence for up to three years.

<table>
<thead>
<tr>
<th>Parent Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Worker Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Supervisor Signature</td>
<td>Date</td>
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</tbody>
</table>

### Child Care Plan (AGENCY USE ONLY)

1. **ELIGIBLE**
   - Ineligible
   - Eligible, placed on waiting list

2. Child Support:  
   - Yes  
   - No
   - Referral
   - Non-Cooperation
   - Good Cause Claim

3. Date Service to Begin: ______________

4. Gross Annual Household Income: ______________

5. ESFC Referral:  
   - Yes  
   - No

6. AMF/CIS Inquiry Date: ______________

7. Date Entered on CCAMIS: ______________

CCAMIS Case#: ______________
Department of Human Resources/Child Care Administration
Purchase of Child Day Care Program
APPLICATION/RECONSIDERATION FOR CHILD CARE

If you have requested other types of assistance in addition to Day Care service, this will be the last page you need to complete.

If you need Day Care only, complete pages 15 & 16.

<table>
<thead>
<tr>
<th>Applicant Name:</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Race:</td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse/Other Parent Name (In Household):</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Social Security #:</td>
<td>Race:</td>
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</table>

Do you now receive AFDC?  □ Yes, When did you start getting AFDC? ________________
□ Not any more, When did you stop getting AFDC? ________________
□ Never

Are you eligible for Transitional Child Care benefits?  □ Yes  □ No
Are you in Project Independence (PI)?  □ Yes  □ No  □ Exempt
If no, do you have a complete Employment Development Plan?  □ Yes  □ No
Are you a relative caretaker (not the mother or father)?  □ Yes  □ No
If yes, how are you related to the child(ren)? ________________
Do you receive AFDC for the child(ren)?  □ Yes  □ No

<table>
<thead>
<tr>
<th>Activity for which you are requesting day care (work, training program, high school/GED, college)</th>
<th>Activity of Spouse/Other Parent (work, training program, high school/GED, college)</th>
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<tbody>
<tr>
<td>Name of school or employer:</td>
<td>Name of school or employer:</td>
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<td>Address of school or employer:</td>
<td>Address of school or employer:</td>
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<td>Phone number:</td>
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<td>Days and hours of your activity:</td>
<td>Days and hours of your activity:</td>
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<td>Start and end dates of activity:</td>
<td>Start and end dates of activity:</td>
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Child Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Race</th>
<th>Sex</th>
<th>Days, Hours &amp; Type of Care, if needed (Family, Center, Certified, Informal)</th>
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DHR/CCA 354 (AA) (Revised 9/95) Previous editions are obsolete.
C. List any household member who is pregnant:  
   NAME: ____________________________  
   DUE DATE: ____________________________

D. List any household member who is disabled:  
   NAME: ____________________________  
   TYPE OF DISABILITY: ____________________________  
   NAME: ____________________________  
   TYPE OF DISABILITY: ____________________________

E. What type of assistance do you or any household member receive now?  
   Under what name: ____________________________  
   Type of Assistance: ____________________________  
   1. ____________________________ 1. ____________________________
   2. ____________________________ 2. ____________________________
   3. ____________________________ 3. ____________________________

F. What type of assistance do you need now? (check all that you need)  
   _____ Cash Assistance  _____ Day Care Services  
   _____ Medical Assistance - Do you have any unpaid medical bills from the past 3 months?  
   _____ YES  _____ NO  
   _____ Food Stamps

G. Do you have any of these problems?  
   _____ Utility shut off  
   _____ No heat  
   _____ Eviction or foreclosure  
   _____ No food  
   _____ No place to stay  
   _____ Other - please specify ____________________________

These are equal opportunity programs. If you believe you have been 
discriminated against because of race, color, age, sex, national origin, 
political beliefs, religion, or physical or mental disability, write to the 
DHRC Equal Opportunity Office, 311 W. Saratoga Street, Baltimore, 
MD 21201, or call 1-800-332-6347.

If you believe you have been discriminated against for 
Food Stamps, write immediately to the 
Secretary of Agriculture, Washington, DC 20250.

You have the right to file an application for Food Stamps immediately by filling out your name and address and signing the front of this Request for Assistance. Benefits 
will be provided from the date we receive this form. You may get Food Stamps right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as checking or savings accounts, are $100 or less.
- Your household has no place to live (homeless).
- Your household is a migrant or seasonal farmworker household.

If you qualify to get Food Stamps right away, we will act on your application within 30 days from the date we receive this form.
DEPARTMENT OF HUMAN RESOURCES REQUEST FOR ASSISTANCE

To request assistance, complete this section and sign your name:

Name:

 LAST     FIRST     MIDDLE INITIAL

Address:

 NUMBER AND STREET

 Mailing Address:

 NUMBER AND STREET OR P.O. BOX

 CITY     STATE     ZIPCODE

 Signature:                      Date:

******************************************************************************

Please fill out A - G if requested by the receptionist. Complete for yourself and all persons who live with you. List your own name on line 1.

A. Last Name, First, Middle, Maiden

<table>
<thead>
<tr>
<th>Relationship to you</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Sex M/F</th>
<th>Race</th>
<th>Applying for this person?</th>
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B. Please list any absent parents of children and past or present spouses not living with you.

<table>
<thead>
<tr>
<th>Absent Parent's Full Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Client ID# (Office Use Only)</th>
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**OFFICE USE ONLY**

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<tr>
<th>Cat.</th>
<th>AU #’s</th>
<th>Status</th>
<th>Cat.</th>
<th>AU #’s</th>
<th>Status</th>
<th>PPI Indicator</th>
<th>Case reassign needed:</th>
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<td>Clearer’s Initials</td>
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<td>Screener’s Initials</td>
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MVA Screened Wage Screened
### Household members older than 13 years of Age

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Race</th>
<th>Sex</th>
<th>Relationship to you</th>
<th>Name of school or employer</th>
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### Income Information

Complete those that apply for household members:

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<thead>
<tr>
<th>Gross Salary</th>
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<th>per</th>
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<tbody>
<tr>
<td>AFDC</td>
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<tr>
<td>Child Support</td>
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<tr>
<td>Other</td>
<td>$</td>
<td>per</td>
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<td>per</td>
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</table>

Attach proof of all income for applicant, spouse, other parent in home, parents of teen parent, adult and spouse with physical custody of teen parent.

### Child Support Information

Are you getting child support for all children in your household who are eligible for child support?  
☐ Yes  ☐ No

Have you applied for child support for all children in your household eligible to receive child support?  
☐ Yes  ☐ No

Do you claim good cause for not pursuing child support for any child in your household eligible for child support?  
☐ Yes  ☐ No

If you claim good cause, you are required to give proof of your claim. The POC worker will send you information and a form to help you with your claim.

Your application gives us information about whether you are eligible for benefits and services. Public money pays for the benefits. You must give true information. Information you give may be checked with public and private agencies and businesses. There are penalties for giving false information. Maryland law states that it is a misdemeanor to get fraudulently, or try to get, public aid. This means deliberately saying something false or pretending to be someone else. It also includes not reporting changes in household or income. Punishment for this is repayment, a fine of up to $1,000, and a possible prison sentence for up to three years.

Parent Signature:  
Date:  
Worker Signature:  
Date:  
Supervisor Signature:  
Date:  

### Child Care Plan (AGENCY USE ONLY)

1. ☐ ELIGIBLE  
☐ INELIGIBLE  
☐ ELIGIBLE, PLACED ON WAITING LIST  
NUMBER IN ELIGIBILITY UNIT:  
2. CHILD SUPPORT:  
☐ Yes  ☐ No  
☐ Referral  ☐ Non-Cooperation  
☐ Good Cause Claim  
3. DATE SERVICE TO BEGIN:  
4. GROSS ANNUAL HOUSEHOLD INCOME:  
5. PRIORITY CODE:  
6. AMF/CIS INQUIRY DATE:  
AMF/CIS CASE#:  
7. DATE ENTERED ON CCAMIS:  
CCAMIS CASE#:  

HR/CCA 354 - Side 2  (Revised 9/95) Previous editions are obsolete.
Department of Human Resources/Child Care Administration
Purchase of Child Day Care Program
APPLICATION/RECONSIDERATION FOR CHILD CARE

PURCHASE OF CHILD CARE
ASSISTANCE REQUEST FORM

ADDENDUM

Applicant Name:

Social Security #:

Address:

Telephone:

Date of Birth:

Race:

Marital Status:

Spouse/Other Parent Name (In Household):

Date of Birth:

Social Security #:

Race:

Do you now receive AFDC? □ Yes, When did you start getting AFDC? □ Not any more, When did you stop getting AFDC? □ Never

Are you eligible for Transitional Child Care benefits? □ Yes □ No

Are you in Project Independence (PI)? □ Yes □ No □ Exempt

If no, do you have a complete Employment Development Plan? □ Yes □ No

Are you a relative caretaker (not the mother or father)? □ Yes □ No

If yes, how are you related to the child(ren)?

Do you receive AFDC for the child(ren)? □ Yes □ No

Activity for which you are requesting daycare
(work, training program, high school/GED, college)

Name of school or employer:

Address of school or employer:

Phone number:

Days and hours of your activity:

Start and end dates of activity:

Activity of Spouse/Other Parent
(work, training program, high school/GED, college)

Name of school or employer:

Address of school or employer:

Phone number:

Days and hours of your activity:

Start and end dates of activity:

Child Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Race</th>
<th>Sex</th>
<th>Days, Hours &amp; Type of Care, if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
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MARYLAND DEPARTMENT OF HUMAN RESOURCES
INCOME MAINTENANCE ADMINISTRATION COMBINED APPLICATION

INTENT TO FILE

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Your Name  Last Name
First        MI       Maiden/Other  Telephone number where you can be reached

Mailing Address
City        State        Zip Code

Social Security Number

Date of Birth        Race        Sex

Sign here

ARE YOU A BOARDER? □ Yes  □ No  IS ANYONE IN YOUR HOUSEHOLD ON STRIKE? □ Yes  □ No

WHAT TYPE(S) OF HELP ARE YOU APPLYING FOR? □ Public Assistance  □ Medical Assistance  □ Food Stamps  □ Day Care (POC)

DO YOU HAVE CHILDREN UNDER AGE 18 LIVING WITH YOU? □ Yes  □ No

CA 1b
**CASE**

<table>
<thead>
<tr>
<th>CASE NAME</th>
<th>R</th>
<th>S</th>
<th>SSN#</th>
<th>DOB</th>
<th>LOCAL DEPARTMENT</th>
<th>DISTRICT OFFICE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CATEGORY CASE NUMBER</th>
<th>AFDC</th>
<th>NPA/MA</th>
<th>WORKER</th>
<th>NEW REOPEN EFF</th>
<th>CARETAKER CHANGE EFF</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF ABSENT PARENT</th>
<th>SOCIAL SECURITY NO.</th>
<th>TELEPHONE NO.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>BIRTH PLACE - CITY - STATE</th>
<th>DATE OF DEATH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST KNOWN ADDRESS</th>
<th>STREET - CITY - STATE</th>
<th>DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST KNOWN EMPLOYER'S NAME AND ADDRESS</th>
<th>DATE</th>
</tr>
</thead>
</table>

**ABSENT PARENT DATA**

<table>
<thead>
<tr>
<th>MARITAL STATUS OF CHILDREN'S PARENTS</th>
<th>DATE MARRIED</th>
<th>DATE AND PLACE DIVORCED OR SEPARATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNKNOWN</td>
<td>MARRIED</td>
<td>DOES ABSENT PARENT CARRY MEDICAL INSURANCE FOR CHILDREN?</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT'S CURRENT OR PRIOR MILITARY SERVICE</th>
<th>WHAT BRANCH?</th>
<th>IS PARENT CURRENTLY PAYING MILITARY ALLOTMENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARMY</td>
<td>NAVY</td>
<td>AIR FORCE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF CHILD</th>
<th>SSN #</th>
<th>DOB</th>
<th>R</th>
<th>S</th>
<th>PATERNITY ESTABLISHED</th>
<th>COURT ORDER SUPPORT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CHILDREN DATA</th>
<th>PATERNITY ESTABLISHED</th>
<th>COURT ORDER SUPPORT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOES PARENT PAY SUPPORT?</th>
<th>TO WHOM DOES PARENT PAY SUPPORT?</th>
<th>DATE SUPPORT LAST PAID</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>SOMETIMES</td>
<td>TO ME</td>
</tr>
</tbody>
</table>

**SUPPORT**

TO RECEIVE AFDC: I assign to the State of Maryland all rights, title, and interest in support that I may have for myself or for any person receiving AFDC. This includes any overdue support that has not been collected. I agree to have the child support agency collect any support owed to me and to keep up to the amount of AFDC paid to me. I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

WHEN I AM ELIGIBLE FOR MEDICAL ASSISTANCE: I assign all rights, title, and interest in medical support and health insurance payments that I may have for myself or any person receiving medical assistance. This includes overdue medical support and health insurance payments that have not been collected. I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of medical assistance payments that have been made for me. I agree to turn over to the State of Maryland any medical support or health insurance payments I receive.

IN ORDER TO CONTINUE TO RECEIVE AFDC OR MEDICAL ASSISTANCE, I will cooperate with the child support agency. If I fail to cooperate with the child support agency, I may lose some of my benefits and my case may be closed. I HAVE READ THESE STATEMENTS OR SOMEONE HAS READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN BY SIGNING MY NAME. I AGREE TO FOLLOW WHAT THEY SAY.

**ASSIGNMENT**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SIGNATURE OF APPLICANT / RECIPIENT / PAYEE</th>
<th>Complete only in cases with representative payee.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SSN#</th>
<th>DOB</th>
<th>RACE</th>
<th>SEX</th>
</tr>
</thead>
</table>

**SIGNATURE**

<table>
<thead>
<tr>
<th>RELATIONSHIP TO CHILD(REN)</th>
<th>TELEPHONE NO.</th>
<th>APPLICANT / RECIPIENT'S ADDRESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NATURE OF NATURAL PARENT IN THE HOME</th>
<th>WITNESS (IF SIGNATURE IS BY &quot;X&quot;)</th>
</tr>
</thead>
</table>

**PRIORITY CASE**

<table>
<thead>
<tr>
<th>CHILD SUPPORT RECEIVED</th>
<th>PATERNAL CARETAKER RELATIVE</th>
</tr>
</thead>
</table>

**ACTION**

3HR/MA 903 (REVISED 3/93) (Previous editions are obsolete, please destroy)