NUTRITION ASSISTANCE PROGRAM

DEPARTMENT OF COMMUNITY OF CULTURAL AFFAIRS
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 501488, As Lito, Saipan, MP 96950
Tel. No.: (670) 237-2801 to 06 / 2870 to 2874
Fax No.: (670) 664-2851

OFFICIAL USE ONLY

DATE RECEIVED: _____
Received By: _____
Case No.: _____ EW: ____
HH Size: _____
No. Employed: _____
Ethnic Code: _____
Dist. No.: _____

☐ ON-GOING ☐ RE-APPLY ☐ NEW APPLICANT

APPLICATION FOR NUTRITION ASSISTANCE

Please answer the questions honestly and completely. If you refuse to give the required information, your household (you and the people who live and eat with you) will be disqualified from participation in the Nutrition Assistance Program.

You may complete this form at home or we can help complete it at our office. Print all information clearly and firmly. If you have any question or problems in completing this Application Form, our Eligibility Worker will be available to assist you.

IMPORTANT: For the interview, please bring proof of all Household Income and Household Composition. For example: check stubs, award letter for government benefits (such as SSI or Social Security), land or house lease or other business or self-employment income statements, alimony or child support documents, statements of all Household Savings and Checking Accounts, birth certificate, C.I. and SS card and any other supporting documents for proper verification.

A. NAME OF HEAD OF HOUSEHOLD

_____
(LAST) (FIRST) (MIDDLE)

B. MAILING ADDRESS

_____
Post Office Box, Island, Zip Code

_____
RESIDENCE

C. TELEPHONE NUMBER WHERE YOU CAN BE REACHED

Home/other _____

Work _____

D. PROVIDE A SKETCH OF HOW TO REACH YOUR RESIDENCE. USE BACK OF APPLICATION. (PAGE 4)

E. HOUSEHOLD COMPOSITION

HOUSEHOLD MEMBER(S) (Last) (First) (Middle)	Relation-ship	Social Security Number	Birthdate	Age	Citizenship		STATUS	
					US	PR	Y/N	Code
1.	HD							
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10								
11.								
12.								

STATUS CODE: A. Under age 18 or age 55 or over. B. Mentally or physically disabled (Statement from a licensed physician or certified psychologist) C. Cares for child under age 12 or incapacitated person in the Household. D. Subject to participating in the Job Training Program. E. Works at least 30 hrs./week or receives weekly earnings equal to CNMI minimum wage X 30 hours. F. High School student over 17 yrs. of age. G. Government retiree.

F. RESOURCES: LIST RESOURCES OF ALL HOUSEHOLD MEMBERS.

1. Cash on hand..... $_____
2. Checking Acct.: Bank Name _____ Acct. No._____ $_____
3. Savings Acct.: Bank Name _____ Acct. No._____ $_____
   Savings Acct.: Bank Name _____ Acct. No._____ $_____
   Savings Acct.: Bank Name _____ Acct. No._____ $_____
   Savings Acct.: Bank Name _____ Acct. No._____ $_____
4. Other (Sav. Cert.; Stocks & Bonds; Negotiable Cert.; etc.)_____ $_____

TOTAL RESOURCES..... $_____

G. EARNED AND UNEARNED INCOME

List each of your Household Earned Income: salaries, wages, payments from roomers, boarders, land leases and house rentals, etc. Also include Unearned Income such as: retirement, child-support, military allotment, contribution, gifts, social security, SSI income, general assistance and any CNMI benefits, etc. Show amount of each income for each Household Member. If non write "None". Provide check-stubs and/or any supporting documents for verification.

Household Member(s)	Earned Inc.	Unearned Inc.	Sources	Total Amount
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

TOTALS: $_____ $_____ $_____

H. SELF-EMPLOYMENT

KIND OF INCOME	YES	NO	APPROXIMATE AMOUNT
1. Farming	☐	☐	$_____
2. Fishing	☐	☐	_____
3. Taxi Business	☐	☐	_____
4. Small Business _____	☐	☐	_____
5. Others _____	☐	☐	_____

TOTAL AMOUNT $_____

I. AUTHORIZED REPRESENTATIVE

You can authorize someone within or outside your Household who is at least 18 years of age to recertify your case for you in a timely manner, to pick up your monthly benefits, and to purchase eligible items with your NAP Coupons. If you would like to authorize someone, write the person's name, relationship, date of birth, social security and telephone number in the space below and provide proof of identification.

NAME (Last/First/Middle)	RL	DOB	SS#	PHONE#
1.				
2.				

J. HAVE YOU OR OTHER HOUSEHOLD MEMBERS EVER RECEIVED FOOD STAMPS? ☐ Yes ☐ No

When did you last received Food Stamps? _____ Where? _____ How much? $_____

PENALTY WARNING

If your Household receives NAP Coupons, it must follow the rules listed below. Any member of your Household who breaks any of these rules and purpose can be barred from the Nutrition Assistance Program for three months to two years; prosecuted under Federal or Commonwealth laws for the crimes of conspiracy, perjury or theft and possibly imprisoned or fined, or both.

DO NOT give false information or hide information, to get or continue to get NAP Coupons.
DO NOT trade or sell NAP Coupons for ATP Cards.
DO NOT alter ATP Cards to get NAP Coupons you're not entitled to receive.
DO NOT use NAP Coupons for any unauthorized purpose or to buy ineligible items, such as, alcoholic drinks or tobacco.
DO NOT use someone else's NAP Coupons or ATP Cards for your Household.

RIGHT TO A FAIR HEARING OR AGENCY CONFERENCE

You or your representative may request a Fair Hearing or Agency Conference either orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by your representative.

READ CAREFULLY BEFORE SIGNING

I declare, under penalty of perjury, that I have given all of the information in this form to the best of my knowledge and belief, I understand it is my duty to report within 10 days to the Nutrition Assistance Program Office any changes in resources, Household Composition, living arrangement and/or income. I authorized the Department of Community and Cultural Affairs, Nutrition Assistance Program, to verify any information given herein.

WARNING: False statements made knowingly in this Application for Nutrition Assistance or in other supporting documents submitted with the Application punishable by fine and/or imprisonment under the provisions of 1 CMC § 5524. All statements made in this Application are subject to verification.

BEFORE YOU SIGN YOUR NAME GO BACK AND CHECK TO SEE THAT EACH ITEM THAT APPLIES TO YOUR HOUSEHOLD HAS BEEN ANSWERED CORRECTLY.

_____ _____

Signature of Adult Head of Household or Authorized Representative — Date

_____ _____

Witness if you signed with an X — Date

_____ _____

Signature of the EW confirming that all informations were provided by the applicant. — Date

We will consider this Application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

W/MOO RE: 30 days app. period.