Cash Assistance Program

Complete this section if you are applying for Cash Assistance (FIP, RCA, SDA). **If not, leave it blank.**

Refugee Status

Are you or any member of your household a refugee or asylee? Yes No

If yes, who?

Arrived in U.S.: [Month/Day/Year]

Medical Coverage

Does anyone in your household have, or expect to have, medical coverage? Yes No

If yes, please list their name(s) and coverage type below.

- Health/hospital insurance (employer, parent, etc.)
- Medicare
- Accident (home or care insurance, etc.)
- MIChild
- Plan/contract (life care contract, etc.)
- Workers' compensation
- Health savings account
- Other _____

Person covered	Name and address of insurance company	Claim, contract/group numbers, effective date

Benefits History

Have you or anyone in your household receive cash benefits in another state? Yes No

If yes, who?

What state?

Last date received: [Month/Day/Year]

Has anyone in your household ever been disqualified or had their benefits reduced or stopped because they did not follow program rules? Yes No

If yes, who?

What state?

Additional Info

Has anyone in your household ever been convicted of a drug-related felony that occurred after August 22, 1996? Yes No

If yes, who?

Convicted more than once? Yes No

Is anyone in your household currently in violation of probation or parole? Yes No

If yes, who?