

**South Carolina Department of Social Services  
Food Stamp Program  
SIMPLIFIED APPLICATION FOR THE ELDERLY**

This application is used for persons applying for food stamps where:

- Everyone in the household is aged 60 or older; or
- All household members aged 60 or older purchase and prepare food separately from the other household members; and
- No member receives earnings from work.

You may file this application by completing at least your name, address and signing the form. If you need help completing this application, call toll-free 1-800-616-1309.

CHIP Case No.:	Date Filed:
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**PLEASE PRINT**

1. Tell us who you are and where you live. We must be able to reach you by telephone.

Last Name:	First Name:	MI:	Phone Where We Can Reach You: (       )	
Street Address: (Include Apt./Lot No.)	City:	State:	Zip Code:	County:
Mailing Address: (If Different, Include Apt./Lot No.)	City:	State:	Zip Code:	

2. Would you like for someone not in your household to complete this application for you or represent you as your authorized representative?  Yes  No If yes, tell us the information below:

Name of Representative: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

3. Tell us who lives with you. List yourself (or the person shown in item 1 above) on the first line.

List Names as They Appear on the Person's Social Security Card (If the person has a card)	List Previous Married Name or Other Names Used	US Citizen	Age	Date of Birth	Social Security Number	Sex Male or Female	Relationship to Name on Line 1	Is anyone hispanic ?	* Race Code (Choose one or more)	Marital Status	Last Grade Completed in School
1 Self		Yes No					Self	Yes No			
2		Yes No						Yes No			
3		Yes No						Yes No			
4		Yes No						Yes No			
5		Yes No						Yes No			

(FOR STATISTICAL PURPOSES ONLY) \* Race: BL - Black or African American; WH - White; AS - Asian/Oriental;  
AI - American Indian/Alaskan Native; NH - Native Hawaiian or Other Pacific Islander

4. Is anyone in your household a fleeing felon or probation/parole violator?  Yes  No

If yes, name: \_\_\_\_\_

5. Was anyone in your household convicted of a controlled substance abuse violation that occurred after Aug. 22, 1996?

Yes  No If yes, name: \_\_\_\_\_

6. Answer the following questions to see if you can get Food Stamps within seven days.

a. Did anyone in your household get any money this month?  Yes  No

If yes, how much? \_\_\_\_\_ When? \_\_\_\_\_

b. Does anyone in your household expect to get any more money this month?  Yes  No

If yes, how much? \_\_\_\_\_ When? \_\_\_\_\_

7. Tell us about the income your household receives. Types of income may include social security benefits, SSI, pensions, veteran's benefits, child support, cash contributions, unemployment, railroad retirement, dividends, interest and any other income.

Type of Income	Who Receives It?	Gross Monthly Income

8. Tell us about the assets your household has. Types of assets include vehicles, bank accounts, property, cash and any other assets.

Type of Asset	Asset Belongs To?	Value of Asset

9. Tell us about your shelter expenses:

Does your household pay mortgage?  Yes  No If yes, list monthly amount: \_\_\_\_\_

Does your household pay rent?  Yes  No If yes, list monthly amount: \_\_\_\_\_

Does your household pay property taxes on your home?  Yes  No If yes, list yearly amount: \_\_\_\_\_

Does your household pay homeowner's insurance?  Yes  No If yes, list yearly amount: \_\_\_\_\_

10. Tell us about your utility expenses:

Does your household pay for heating or cooling costs?  Yes  No

If your household does not pay for heating or cooling costs, do you pay for other utilities?  Yes  No

If yes, list the utility costs you pay: \_\_\_\_\_

11. Does anyone in your household pay out-of-pocket medical expenses over \$35 per month?

(For example, prescriptions, doctor visits, hospital, health insurance, etc.)  Yes  No

If yes, and to receive credit for these out-of-pocket medical expenses, you must list each type of medical expense and the monthly amount you are paying:

_____ \$ _____	_____ \$ _____	_____ \$ _____
_____ \$ _____	_____ \$ _____	_____ \$ _____
_____ \$ _____	_____ \$ _____	_____ \$ _____

List any outstanding doctor or hospital bills that you owe and must pay out of your own pocket:

_____ \$ _____	_____ \$ _____	_____ \$ _____
_____ \$ _____	_____ \$ _____	_____ \$ _____

You may attach an itemized listing of your prescriptions from your pharmacy.

12. Does anyone in your household pay legally obligated child support to someone living outside of your home?

Yes  No If yes, how much per month? \_\_\_\_\_

13. Please read and sign this statement/application.

**I certify that the information I or my authorized representative have provided above is true to the best of my knowledge. I give permission for the Department of Social Services to make any necessary contacts to check my statements. I know that I could be penalized if I knowingly give false information. I certify I received the *Your Rights and Responsibilities* handout from my caseworker.**

**Signature of Applicant/Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of two witnesses, if signed by an "X": (1) \_\_\_\_\_ (2) \_\_\_\_\_