MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR FAMILY INDEPENDENCE

Request for Assistance Received Date: _____

CME003

If your primary language is not English, please list: _____

To file this application right away, give us your name, address, and signature (or that of an authorized representative). If eligible, your benefits will begin the date this information is received.

Your Name (First, Middle Last)	Social Security #	Birth date: (Month/Day/Year)
Mailing Address: Street, PO Box, RR or RFD (Include apartment number, care of, etc.)		

City	State	Zip Code	Telephone/Message Number
Street, address and town where you actually live, if different			

I would like to apply for whatever help I can get with:

☐ Medical Services ☐ Long Term Care ☐ Cash Assistance
☐ Food Assistance - If you want Food Supplement assistance, complete the section in blue.

If your household has little or no income, you may be able to get Food Supplement benefits within a few days. Just answer the following questions, and sign this application form.

Are all household members homeless and without free shelter? No ____ Yes ____
Do you pay separate for heat? No ____ Yes ____
Did all of the household income stop recently? No ____ Yes ____
Is anyone in your household a migrant or seasonal farm worker? No ____ Yes ____
Has anyone received HEAP Fuel Assistance at your current residence since last October? No ____ Yes ____
How many people, including yourself, live in your home and purchase and prepare meals with you? _____
What is the total income you expect your household to receive this month? $_____
How much do the members of your household have in cash or savings? $_____
How much is your rent or mortgage? $_____
How much are your utilities? $_____

_____ _____
Applicant's Signature Date

If you have a guardian, conservator or someone who knows your situation and you would like us to contact them to help with this application, please complete the following:

Name_____**Address**_____

Telephone_____ _____