

MARYLAND DEPARTMENT OF HUMAN SERVICES  
FAMILY INVESTMENT ADMINISTRATION

APPLICATION FOR EMERGENCY ASSISTANCE

Date Signed Application  
Received in  
Local Department

MUST BE DATE STAMPED

APR 23 2025

For Case Manager Use Only:

LDSS Office Case Manager Name Appointment Date Appointment Time AU ID

WHAT IS YOUR EMERGENCY?

BGE turn off

NORTHEAST REGIONAL OFFICE

Have you or anyone living with you applied for or received Emergency Assistance, Public Assistance or SNAP benefits in Maryland? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes: Who Applied? What Type?	Client ID	Date of Last Assistance
		Amount Received \$	

Have you or anyone living with you received Emergency Assistance, Public Assistance or SNAP benefits in another state? If YES- Who Type: Date last assistance received:

1. INDIVIDUAL INFORMATION {CLRE/DEM2/ALAS} Complete the section below for you and all persons who live with you. List your name first:

NAME Last First Middle Jr. III, etc. Maiden/Other	Relationship To YOU	Date of Birth Mo/Day/Yr.	Social Security Number	Sex M/ F	*Ethnicity	*Race	U.S. Citizen?	INS Status
Jones Kenneth Marie	SELF	11-28-84	219-25-1011	F		AA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Jones Maysyn Marie	daughter	5-14-19	868-68-1581	F		AA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Jones Majer Tyrene	son	5-14-19	142-73-7339	M		AA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	

\*Use the codes below to complete the Race and Ethnicity blocks. Enter each code that applies, using at least one code for each person. **Ethnicity Codes:** 1= Hispanic or Latino, 2=Not Hispanic/Latino. **Race Codes:** You can choose one or more race code - 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

**Note:** You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

Are you or anyone who lives with you pregnant? ☐ Yes ☒ No If Yes, Who? What is the due date?

What language do you speak? ☒ English ☐ Spanish ☐ Other

If you do not speak English and need free translation services, tell your case manager.

Are you visually impaired? ☐ Yes ☒ No Are you hearing impaired? ☐ Yes ☐ No

2. WHERE DO YOU LIVE? (NAME)

Number 3709	Street Ferndale Ave	Apt. No.	Floor No.	Telephone Number 410-512-7164
City Baltimore	State Md	Zip Code + 21207	Telephone Number where you can be reached	

3. LIST YOUR MAILING ADDRESS IF DIFFERENT FROM WHERE YOU LIVE (NAME)

Number	Street	Apt. No.	Floor No.
P.O. Box	City	State	Zip Code + 4

4. PREVIOUS ADDRESS {ADDR/PRE} List any other address where you lived in the last 12 months:

Number	Street	Apt. No.	Floor No.
P.O. Box	City	State	Zip Code + 4

When did you live there? From: To:

5. AUTHORIZED REPRESENTATIVE (If Desired) {CIRC/AURP} List the name and address of your authorized representative:

Name {First, Middle, Last}	Relationship to You	Telephone Number
Number	Street	Apt. No. Floor No. P.O. Box City State Zip Code + 4

Check what you want the representative to do: ☐ Complete interview for you ☐ Sign your application  
☐ Receive your notices

- ✧ You must tell us about the citizenship and immigration status for each family member who wants benefits.
- ✧ Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household's eligibility and benefit amount.

### Citizenship and Immigration Status

- ✧ You must give us a social security number for each family member who wants benefits.
- ✧ If a person who wants benefits does not have a social security number, that person must apply for a number. We can help applicants get their numbers.
- ✧ If a family member has applied for a social security number, we will not delay your application while you wait for the number.
- ✧ We use social security numbers to prove income. We do not give numbers to other agencies like Immigration and Customs Enforcement.

### Social Security Numbers

## FACTS YOU SHOULD KNOW ABOUT APPLYING FOR TEMPORARY CASH ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (FORMERLY FOOD SUPPLEMENT PROGRAM), EMERGENCY ASSISTANCE TO FAMILIES WITH CHILDREN AND MEDICAL ASSISTANCE

6. VENDOR INFORMATION (EAFI/END) List the name and address of the person or company to be paid (if not you):									
Name (First, Middle, Last)		Apt. No. Floor No.		P.O. Box		City		State Zip Code + 4	
Social Security No. or Federal ID No. (of Company)		Telephone Number							
7. ASSETS (EAWs) If you or anyone who lives with you has any assets listed below, fill in the amount(s).									
ASSET TYPE		AMOUNT		ASSET TYPE		AMOUNT		ASSET TYPE	
Savings Account/Credit Union		\$		Checking Account		\$		Cash	
Property Other than Home		\$		Stocks/Bonds		\$		Insurance	
Other, list:				Other, list:		\$			
8. COMMUNITY RESOURCE (EAWs) If you or anyone who lives with you has received contributions from others, list names and amount(s).									
NAME		AMOUNT		NAME		AMOUNT			
		\$				\$			
9. INCOME (EAWs/ERN1/DEMS) If you or anyone who lives with you works or receives other income, list name(s) and amount(s):									
INCOME TYPE		AMOUNT		HOW OFTEN?		INCOME TYPE		AMOUNT	
Public Assistance		\$				Gross Salary, Wages, Tips		\$ 219.00 bi-weekly	
Support from Parent/Spouse		\$				Social Security		\$	
Unemployment		\$				Worker's Compensation		\$	
Insurance Benefits		\$				Railroad Retirement		\$	
						Other, list:		\$	
Have you or anyone who lives with you stopped working? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Date Job Ended: _____									
Reason for Leaving: _____									
If Yes, Who? _____									
Are you or anyone who lives with you on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If Yes, Who? _____									
10. EXPENSES (EAWs) If you or anyone who lives with you has any expenses list them below, fill in this section:									
EXPENSE TYPE		AMOUNT		HOW OFTEN?		EXPENSE TYPE		AMOUNT	
Rent or Mortgage		\$ 2400		monthly		Oil/Other Fuel		\$	
Telephone		\$ 100		monthly		Food Costs		\$ 200.00 monthly	
Mandatory Working Expenses		\$ 40.00 weekly		weekly		Other, list:		\$	
Child Care		\$ 90.00 monthly		monthly		Other, list:		\$	



**READ BEFORE SIGNING:**

I understand that it is important to give true information and if I do not, I am breaking the law.

I understand that I can be fined, imprisoned, or have my benefits reduced for making false statements or for pretending to be another person.

I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I understand that if I get more SNAP benefits than I should, all adult members of my household are liable for repaying the debt.

I know the Department can use the application against me in a court of law for fraud prosecution.

I know that failing to report or verify shelter, medical or dependent care expenses, or child support payments is the same as saying I do not want a deduction for the expenses I did not verify or report.

I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

I understand by signing this application:


- I accept cash assistance including Emergency Assistance to Families with Children (EAFIC) and/or medical assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review, and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

**SIGNATURE SECTION**

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits, and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Services Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Services' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief, and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

Signature of Applicant/ Recipient		Date 4.23.25
Signature of Witness (If you Signed an X)		Date
Signature of Spouse (If Applicable)		Date
Signature of Authorized Representative (If Applicable)		Date
Signature of Case Manager		Date

**I do not wish to apply for assistance at this time. I withdraw my application for:**

are not exempt for work registration under one of the above reasons or they reside in an area that is designated as exempt, are required to be work registered and participate in a work program/activity or be employed.

These individuals known as ABAWDS may only receive SNAP benefits for three months in a fixed 36 month period unless the individual is employed or participating in an approved work or educational activity a minimum of 80 hours per month. The individual may not receive SNAP benefits again until he or she meets the work requirements. You will receive additional information from the case manager and information is available on the DHS website at <http://www.DHR.state.md.us/blog/>

#### **MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.**

Every person convicted of "Medicaid Fraud" with a value of \$500 or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be subject to a fine of no more than \$10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than \$500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than \$1,000 and imprisoned for no longer than three years or both.

#### **TCA and SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM PENALTIES**

**Do not:**

- Give false information or withhold information to get or continue to get TCA and/or SNAP benefits.
- Trade or sell TCA or SNAP benefits, or electronic benefit cards.
- Use TCA and SNAP or electronic benefit cards to buy items not allowed, such as alcohol and tobacco or to pay on credit accounts.
- Use someone else's TCA or SNAP benefits.
- Use someone else's Electronic Benefits Card without authorization.
- Use your EBT card containing TCA benefits in a liquor store, adult entertainment venue such as a strip club, or in a gambling establishment such as a casino.

Your SNAP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the TCA or SNAP.


- We may bar this person for **one year** after the first violation.
- We may bar this person for **two years**:
  - \* After the second violation, or
  - \* After the first time, a court finds this person guilty of buying illegal drugs with TCA or Supplemental Nutrition Assistance Program benefits.
- We may bar this person **permanently**:
  - \* After the third violation, or
  - \* After the second time, a court finds a person guilty of buying illegal drugs with TCA or SNAP benefits, or
  - \* After the first time, a court finds this person guilty of buying guns, bullets, or explosives, with TCA SNAP benefits.
- \* After a court finds this person guilty of trafficking TCA or SNAP benefits of \$500 or more.

- We may bar this person for ten years if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

A judge can also fine this person up to \$250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.

Individuals who request four or more replacement Independence cards in one year may be referred to the Office of the Inspector General for investigation of trafficking benefits.



<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Supplemental Nutrition Assistance Program <input type="checkbox"/> Medical Assistance		
<input type="checkbox"/> Emergency Assistance to Families and Children		
Signature of Applicant, Recipient, Authorized Representative		Date
<b>I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.</b>		
Signature 		Date
Printed Name <i>Kenneth Jones</i>		4-23-25

<b>FOR CASE MANAGER USE ONLY</b>	
AU ID	<div style="text-align: center;"> <b>RECEIVED</b>  <b>APR 23 2025</b>  <b>NORTHEAST REGIONAL OFFICE</b> </div>
Emergency Type code	
Need Type	
Cost of Need	
Vendor ID	
Verifications	

### USDA Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](http://www.fns.usda.gov/snap/contact_info/hotlines.htm) (click the link for a listing of hotline numbers by State); found online at: [http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.





## For customers accessing TTY

1. Dial 7-1-1 or [800-735-2258](tel:800-735-2258) to initiate a TTY call through Maryland Relay.
2. The Maryland Relay Operator's typed greeting, including the Operator's identification number, will display on your TTY or VCO phone.
3. When the Operator is finished typing, you will see the letters "GA." This means "Go Ahead."
4. Type the number of the person you want to call, along with any special calling instructions.
5. Then type "GA".

### **Authorization to Receive Family Planning Information**

If you want information, you can ask your case manager for a Family Planning Guide. You may also contact:

- 1-800-546-8900 if you need help in finding a provider for birth control or arranging prenatal care, or
- The Center for Maternal and Child Health at 410-767-6713 [www.fha.state.md.us/mch](http://www.fha.state.md.us/mch)

## YOU HAVE THE FOLLOWING RESPONSIBILITIES

**PROVIDE INFORMATION** – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, U.S.C.2011-2036, Social Security Act §1137(f), and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank, or other party. We may also contact local, state, or federal agencies to make sure the information is correct. We can give your information to other federal or State agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

- You may have to repay the money for the benefits, and
- We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

**REPORT CHANGES** - You must report all changes within ten days unless you are part of the Supplemental Nutrition Assistance Program simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

**Warning – We may deny, lower, or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.**

### ***WORK REQUIREMENTS FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM***

Individuals applying for or receiving Supplemental Nutrition Assistance Program (SNAP) benefits must know and understand the following information about the Supplemental Nutrition Assistance Program work registration and work requirements. SNAP work requirements are covered in federal law at 7 CFR 273.24.

Everyone over age 18 **is required to be registered for work** unless otherwise exempt, because they are: over age 60, caring for a child under age 6 living in their home, applied for or receiving unemployment benefits, self-employed- working a minimum of 30 hours or more per week at the equivalent of federal minimum wage, attending a recognized school or institution of higher education at least half time, or the individual is mentally or physically unfit for work. Work registration is not the same as participation.

Beginning **January 1, 2016**, able-bodied individuals without dependents (ABAWDS), ages 18-50, who

## Information

- ✧ If a family member will not tell us about citizenship, immigration status, or social security number, that person will not get benefits.
- ✧ They must still give us proof of income, expenses, and other things.
- ✧ The other family members who give us their information will get benefits if they meet the rules.

## Emergency Medical Assistance

- ✧ Immigrants who are not eligible for other kinds of medical assistance and apply only for emergency medical assistance do not have to tell us their social security number, immigration, or citizenship status.

## Time Limits

- ✧ Temporary Cash Assistance has time limits.
- ✧ The Supplemental Nutrition Assistance Program (formerly Food Supplement Program) and Medical Assistance do not have a time limit.
- ✧ When Temporary Cash Assistance ends because of time limits, earnings, or other reasons, you may still get SNAP benefits and Medical Assistance.

## Interviews

- ✧ You, a responsible family member or someone you choose to represent you must be interviewed.
- ✧ In most cases, we can interview you by telephone.
- ✧ You must give or send us the proof we ask for at your interview.

## If you need help:

Applying for benefits, or  
Have questions about information you must give us,  
Want to know what will happen to your benefits  
Do not speak English and need free translation services  
Call your case manager or call 1-800-332-6347  
Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.

NORTH CAROLINA  
NORTH CAROLINA OFFICE

RECEIVED

## Requesting a Reasonable Accommodation

If you are an individual with a disability, you may be entitled to reasonable accommodation to help you access DHS' activities, programs, and services. This applies even if you are working with a local department of social services or a vendor who provides services for DHS' customers.

A reasonable accommodation is a modification or adjustment to an activity, program, or service, which helps a qualified individual with a disability have meaningful access to DHS' activities, programs, and services.

## Examples of Reasonable Accommodations:

**Hearing Impairment:** sign language interpreter, providing an assistive listening device  
Visual Impairment: having a qualified reader read to a customer  
Mobility Impairments: mailing forms to a customer; meeting a customer at a more accessible location  
**Developmental Disabilities:** Having things written down; taking breaks; scheduling appointments around a customer's medical needs

You may request a reasonable accommodation from the local department of social services or a vendor at any time. Your request may be oral or written. A request for a reasonable accommodation may be made in person, in writing, or over the telephone. There are no particular words that you need to use to request an accommodation. A request may be made by you or someone helping you. If you need to request a reasonable accommodation because of your disability, you should speak with the case manager or the supervisor or the Customer Access Coordinator (CAC) at your local department of social services. Ask the case manager for the name of the Customer Access Coordinator at your local department of social services. You may also ask for more information at the front desk.





# EMERGENCY ASSISTANCE TO FAMILIES WITH CHILDREN (EAFC) DECLARATION

I understand that the benefits I may receive are limited to once in a 12-month period. These funds are only available after all other resources have been explored and it has been determined that the EAFC benefit will alleviate the emergency and prevent it from reoccurring.

I understand that I will not be eligible to receive another EAFC benefit for a period of 12-months.

By accepting this payment, I acknowledge that I have a sufficient funds to resolve this emergency.

Director  
Brandi Stocksdaie, LCSW-C  
  
Director's Office  
443-378-4600  
  
Website  
[dhr.maryland.gov/local-offices/baltimore-city/](http://dhr.maryland.gov/local-offices/baltimore-city/)  
  
Talmadge Branch Building  
1910 N. Broadway  
Baltimore, MD 21213  
  
facebook.com/baltimoredss  
twitter.com/baltimoredss

Governor  
Wes Moore  
  
Lt. Governor  
Aruna Miller  
  
Acting Secretary  
Rafael López  
  
Mayor  
Brandon M. Scott

Kenneth Jones

**Customers Name**

4.23.23

**Date**

[Signature]

**Customers Signature**

**Customers Clt. ID #**



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APR 23 2025

NORTHEAST REGIONAL OFFICE

Employee's Earnings Statement  
STATE OF MARYLAND  
MD DEPT OF HUMAN SERVICES  
330700 LOCAL DEPT OPERATIONS

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Name KENNEITH M JONES					Document ID RG1071	
Regular Pay Rate .00			Pay Period Ending Date 04-15-2025		Check/Advice Number 56304896	
F.Mar.Stat. M	Fed. Ex. 0	Additional Fed. Tax	St.Mar.Stat. M	St. Ex. 3	Additional St. Tax	County Code BC
W4 Step 2 N		W4 Step 3		W4 Step 4a		W4 Step 4b

EARNINGS	HOURS	CURRENT	YEAR TO DATE	TAXES/DEDUCTIONS	CURRENT	YEAR TO DATE
REGULAR	80.0	2526.30	20264.26	FEDERAL TAX	47.74	365.65
OVERTIME		0.00	1077.65	FICA/MED	147.40	1265.68
*ST PD BENEFITS				STATE TAXES	105.87	937.68
FICA SUBSIDY		147.40	1265.68	PHARMACY PLAN	65.99	527.92
PHARMACY SUB		263.97	2111.76	HLTH CARE ACCT	133.33	1066.64
DENTAL SUBSIDY		28.05	224.40	DEPN CARE ACCT	208.33	1666.64
RET/PEN SUB		554.78	4450.07	UCC DENTIL DPPO	28.05	224.40
UNEMPL INS SUB		2.70	23.16	AD & D PLAN	3.45	27.60
HEALTH INS SUB		647.79	5182.32	TERM LIFE INS	2.00	16.00
				ADDIT TERM INS	3.20	25.60
				WAGE GARN FEE	2.00	16.00
				401K-SAVE	118.00	944.00
				ST EMP ALT PEN	177.53	1422.42
				CF BCBS PPO	161.94	1295.52
				DIR/DEP-CHCKNG	1180.11	10415.25
				AFSCME DUES	27.69	213.95
				AFSCME INS	38.87	310.96
				GRN/LN AGREE 1	75.00	600.00

Current  
Year To Date

Earnings	Taxes	Deductions	Net Pay
2526.30	301.01	1045.18	1180.11
21341.91	2569.01	8357.65	10415.25

KENNEITH M JONES  
3709 FERNDAL AVE  
BALTIMORE MD 21207

FOR YOUR CONVENIENCE ENROLL IN DIRECT DEPOSIT

Payment type:

Bank Name:

Deposit Date:

Deposit Amount:

Direct Deposit

SUTTON BANK

04-23-2025

\$ 1180.11

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NORTHEAST REGIONAL OFFICE



Employee's Earnings Statement  
STATE OF MARYLAND  
MD DEPT OF HUMAN SERVICES  
330700 LOCAL DEPT OPERATIONS

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Name KENNEITH M JONES					Document ID RG1071		
Regular Pay Rate .00			Pay Period Ending Date 04-01-2025		Check/Advice Number 56193530		
F.Mar.Stat. M	Fed. Ex. 0	Additional Fed. Tax	St.Mar.Stat. M	St. Ex. 3	Additional St. Tax	County Code BC	
W4 Step 2 N	W4 Step 3		W4 Step 4a		W4 Step 4b		

EARNINGS	HOURS	CURRENT	YEAR TO DATE	TAXES/DEDUCTIONS	CURRENT	YEAR TO DATE
REGULAR	80.0	2526.30	17737.96	FEDERAL TAX	64.32	317.91
OVERTIME	3.5	165.79	1077.65	FICA/MED	160.07	1118.28
*ST PD BENEFITS				STATE TAXES	119.05	831.81
FICA SUBSIDY		160.07	1118.28	PHARMACY PLAN	65.99	461.93
PHARMACY SUB		263.97	1847.79	HLTH CARE ACCT	133.33	933.31
DENTAL SUBSIDY		28.05	196.35	DEPN CARE ACCT	208.33	1458.31
RET/PEN SUB		554.78	3895.29	UCC DENTL DPPO	28.05	196.35
UNEMPL INS SUB		2.93	20.46	AD & D PLAN	3.45	24.15
HEALTH INS SUB		647.79	4534.53	TERM LIFE INS	2.00	14.00
				ADDIT TERM INS	3.20	22.40
				WAGE GARN FEE	2.00	14.00
				401K-SAVE	118.00	826.00
				ST EMP ALT PEN	177.33	1245.09
				CF BCBS PPO	161.94	1133.58
				DIR/DEP-CHCKNG	1303.47	9235.14
				AFSCME DUES	27.69	186.26
				AFSCME INS	38.87	272.09
				GRN/LN AGREE 1	75.00	525.00

	Earnings	Taxes	Deductions	Net Pay
Current	2692.09	343.44	1045.18	1303.47
Year To Date	18815.61	2268.00	7312.47	9235.14

KENNEITH M JONES  
3709 FERNDAL AVE  
BALTIMORE MD 21207

FILE STATE TAX RETURN FREE USING IFILE - WWW.MARYLANDTAXES.GOV

Payment type:

Bank Name:

Deposit Date:

Deposit Amount:

Direct Deposit

SUTTON BANK

04-09-2025

\$ 1303.47

RECEIVED

APR 23 2025

NORTHEAST REGIONAL OFFICE

Employee's Earnings Statement  
STATE OF MARYLAND  
MD DEPT OF HUMAN SERVICES  
330700 LOCAL DEPT OPERATIONS

000

Name KENNEITH M JONES					Document ID RG1071	
Regular Pay Rate .00			Pay Period Ending Date 03-18-2025		Check/Advice Number 56083649	
F.Mar.Stat. M	Fed. Ex. 0	Additional Fed. Tax	St.Mar.Stat. M	St. Ex. 3	Additional St. Tax	County Code BC
W4 Step 2 N		W4 Step 3		W4 Step 4a		W4 Step 4b

EARNINGS	HOURS	CURRENT	YEAR TO DATE	TAXES/DEDUCTIONS	CURRENT	YEAR TO DATE
REGULAR	80.0	2526.30	15211.66	FEDERAL TAX	66.69	253.59
OVERTIME	4.0	189.48	911.86	FICA/MED	161.88	958.21
*ST PD BENEFITS				STATE TAXES	120.93	712.76
FICA SUBSIDY		161.88	958.21	PHARMACY PLAN	65.99	395.94
PHARMACY SUB		263.97	1583.82	HLTH CARE ACCT	133.33	799.98
DENTAL SUBSIDY		28.05	168.30	DEPN CARE ACCT	208.33	1249.98
RET/PEN SUB		554.78	3340.51	UCC DENTL DPPO	28.05	168.30
UNEMPL INS SUB		2.96	17.53	AD & D PLAN	3.45	20.70
HEALTH INS SUB		647.79	3886.74	TERM LIFE INS	2.00	12.00
				ADDIT TERM INS	3.20	19.20
				WAGE GARN FEE	2.00	12.00
				401K-SAVE	118.00	708.00
				ST EMP ALT PEN	177.33	1067.76
				CF BCBS PPO	161.94	971.64
				DIR/DEP-CHCKNG	1321.10	7931.67
				AFSCME DUES	27.69	158.57
				AFSCME INS	38.87	233.22
				GRN/LN AGREE 1	75.00	450.00

	Earnings	Taxes	Deductions	Net Pay
Current	2715.78	349.50	1045.18	1321.10
Year To Date	16123.52	1924.56	6267.29	7931.67

KENNEITH M JONES  
3709 FERNDAL AVE  
BALTIMORE MD 21207

FILE STATE TAX RETURN FREE USING IFILE - WWW.MARYLANDTAXES.GOV

Payment type:

Bank Name:

Deposit Date:

Deposit Amount:

Direct Deposit

SUTTON BANK

03-26-2025

\$ 1321.10

RECEIVED

APR 28 2025

NORTHEAST REGIONAL OFFICE



**This is a turn-off notice.**

Issued Date: April 8, 2025  
Account # 0345180000  
Kenneith Marie Dukes  
3709 Ferndale Ave  
Baltimore MD 21207

**RECEIVED**

**APR 23 2025**

**NORTHEAST REGIONAL OFFICE**



**HOW TO KEEP SERVICE ON:**

**TAKE ACTION BY: April 22, 2025**

**IF YOU CAN'T PAY**

We are here to help. If you can't pay your total past due balance, here are options to avoid termination: Call **800.332.6347** for Energy Assistance, visit **BGE.COM/Assistance** for a self-serve payment arrangement, or call **800.685.2210** for assistance with setting up a payment arrangement Monday-Friday, 8 am-6 pm.

**IF YOU CAN PAY**

See reverse side for payment options. **DO NOT MAIL**, we may not receive your payment in time. If your check is returned by the bank, service is subject to turn-off without further notification.

**IF YOU DO NOT TAKE ACTION AND SERVICE IS TERMINATED**

If full payment is not paid by the date shown above and service is disconnected, you can get service restored the same day if you make payment by 3pm that day through one of the payment options on the reverse side. After service is turned off, all past due bills must be paid before service will be restored. A reconnection charge will be assessed, and a security deposit may be required.



**This is a turn-off notice.**

See reverse side for more info ►

0107981 01 AV 0.54 \*\*AUTO T3 0 3071 21207-716409 -C02-P07988-IO



Kenneith Marie Dukes  
3709 Ferndale Ave  
Baltimore, MD 21207-7164



**Account # 0345180000**

**Total amount due as of Apr 8, 2025 \$5,019.29**

**Payment Amount \$**

BGE  
P.O. Box 13070  
Philadelphia, PA 19101-3070

25034518000060005019293112600050192900



BALTIMORE CITY

COMMUNITY  
ACTION PARTNERSHIP



MAYOR'S OFFICE

CHILDREN  
FAMILY SU

DATE: 4/23/25

APPLICANT'S NAME: Kenneth Jones

ADDRESS: \_\_\_\_\_

SERVICE: \_\_\_\_\_

EXTENSION DATE: \_\_\_\_\_

## ITEMS DROPPED OFF

- ☒ ID FOR \_\_\_\_\_
- ☒ PAY STUBS FOR \_\_\_\_\_
- ☒ S.S. CARDS FOR \_\_\_\_\_
- ☐ PROOF OF RESIDENCE
- ☐ WATER BILL
- ☒ BGE BILL/ACCT # \_\_\_\_\_
- ☐ ZERO DEC FOR \_\_\_\_\_
- ☐ HOUSEHOLD WORKSHEET
- ☐ RESOURCE PROVIDER STATEMENT
- ☒ APPLICATION
- ☐ PROOF OF INCOME (SSI, SSA, TCA, TDAP, TAX DOC. RET/PEN, TAXES) FOR \_\_\_\_\_
- ☐ OTHER \_\_\_\_\_

RECEIVED

APR 23 2025

NORTHEAST REGIONAL OFFICE

Assigned Worker: drop off

Submitted by: \_\_\_\_\_

Collected by: mmcIntosh

CHECK STATUSES: [myohepstatus.org](http://myohepstatus.org) or call 410-396-5555

DROP OFF FORM



**MARYLAND DEPARTMENT OF HUMAN SERVICES  
FAMILY INVESTMENT ADMINISTRATION  
REQUEST FOR INFORMATION TO VERIFY ELIGIBILITY**

2. DATE 4-23-25 3. CL ID /AU NUMBER 326 797 446  
4. CASE NAME Kenneth Jones  
5. CASE MANAGER NERO  
6. TELEPHONE NUMBER 443-423-6400

**1. Local Department**

Fax: 443-423-6201/6400  
BCDSS.NERO@maryland.gov

**DEAR CUSTOMER:** To get benefits you must give us the proofs **MARKED BELOW** for you and **ALL PERSONS FOR WHOM YOU ARE APPLYING**. If you have any questions or need help to get the proofs, please call me. Thank you.

DATE: 5-2-25

- ☐ Bring the proofs to an interview ☐ Bring or send them to me no later than...

PROOF OF INCOME Required for all programs. We cannot issue benefits if you do not verify the checked items		PROOF OF IDENTITY Only one PROOF needed for TCA and FSP But more than one may be needed for MA		MOST RECENT PROOF OF EXPENSES Not required but if you provide of these expenses, you might get more benefits	
Pay stubs – last _____		Social Security Number		X	Heat, Lights, Telephone, Water, Sewage Trash Removal, Other Utilities
Statement on Employer's Letterhead		Birth or Baptismal Certificates		X	*Rent Mortgage Receipts
Tax Return 20_____		Drivers Licenses			*Amount of Shared Expenses
Unemployment benefits		Alien Registration cards or alien numbers for: _____		X	*Child or Adult Dependent Care
Union/Strike benefits		Marriage License/Divorce Decree			Property Taxes/Homeowners Insurance
Child support or alimony you receive		Affidavit from another person			Medical Bills
Social Security Benefits		Citizenship			Child support or alimony you pay to someone outside your home
SSI/SSDI Benefits		Other			Other
Veteran's Benefits or Other Pensions		Other			
Education Loans/Grants/Scholarships		<b>Proof of Living Arrangement</b>			School Attendance and Financial Aid Form 604 or 690
Military Allotments		1130 form <b>Not to be used for proof of who lives with you.</b>			Address of Absent Parent/s
*Proof of expenses paid by Others		Other _____			Pregnancy/Prenatal Care
*Contributions from others		<b>PROOF OF ASSETS (Case manager: Not required for categorical elig FSP)</b>			Disability Incapacitation
*From Roomers or Boarders		Checking and Savings Accounts			Application for Other Benefits
Rental/Mortgage Income		Certificates of Deposit (CD's, IRA's and Keogh Accounts)			Proof of Who Lives With You
Self Employment Records		Stocks, Bonds, Mutual Funds			Report Cards
Workman's Compensation		Dividends and Interest			Health Care Forms
Wage Form		Life and Health Insurance			Type of Housing
Other _____		Other _____			

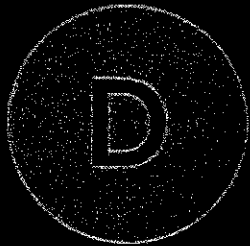
**\*IMPORTANT:** These proofs must include the name, address and telephone numbers of the person making the statement. If you need assistance getting these proofs, please let me know.

HEAP Results, past 30 days of Paid Expenses Proof of Spouse whereabouts

The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. To request a reasonable accommodation for a disability, please contact the case manager listed above or call 1-800-332-6347.

**This institution is an equal opportunity provider.**





**Damien Barber**

Mar 28 at 1:02 PM

For March Rent

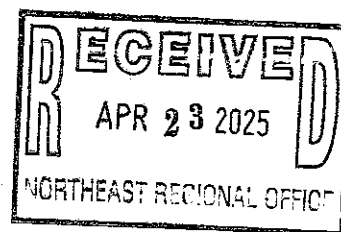
**\$2,400.00**

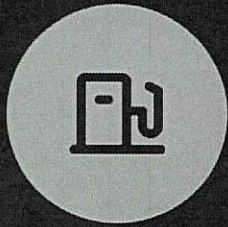
**Transaction details**



**Complete**

Payment sent successfully

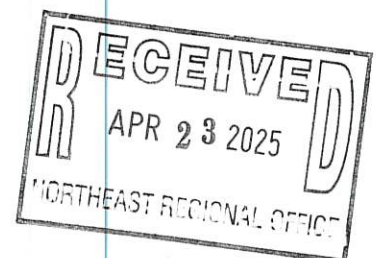


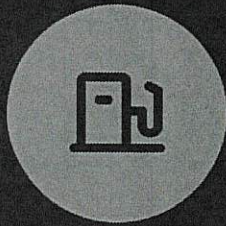


# Security Cmf

Apr 5 at 4:16 PM

# \$10.13

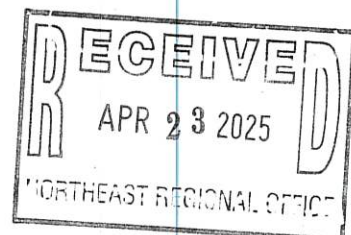




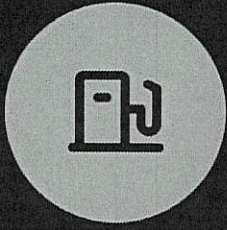
# Security Blvd

Apr 15 at 11:05 AM

# \$40.00



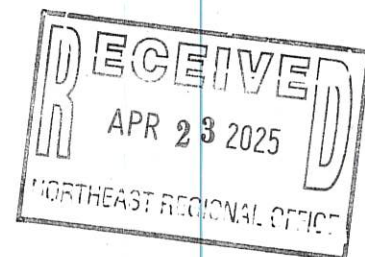


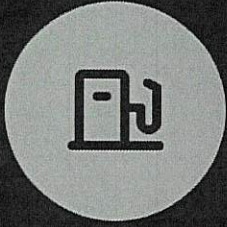


# Garrison Blvd Cm

Apr 8 at 8:00 AM

# \$40.00





# Garrison Blvd Cm

Mar 26 at 7:38 AM

# \$37.60







# Global Lending Service

Yesterday at 6:14 PM

**\$698.48**







Five Below

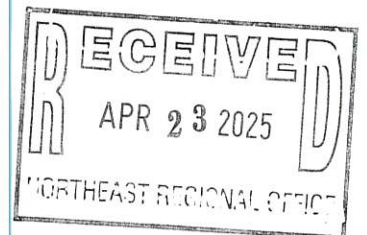
Apr 14 at 4:31 PM

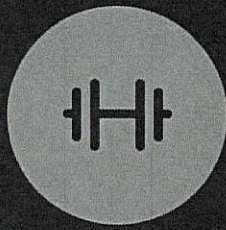
\$22.26

K. Jones  
CID# 326797446

Cherise  
Mordant

?





# Centers Advanced Ortho

Apr 11 at 8:49 AM

**\$30.00**





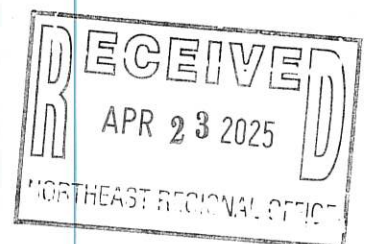


# DICK'S Sporting Goods

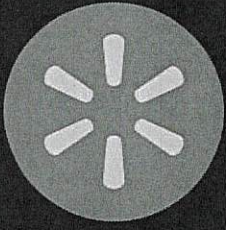
Apr 4 at 1:19 PM

# \$47.70

7







**Walmart**

Mar 27 at 2:56 PM

**\$90.40**

7



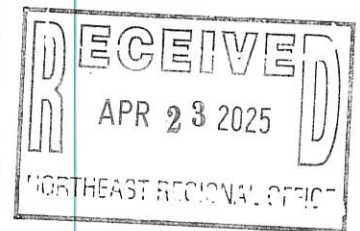


# The Children's Place

Mar 27 at 3:25 PM

**\$63.39**

7





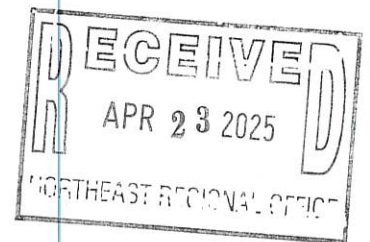


Target

Mar 28 at 8:34 AM

\$63.48

7  
1





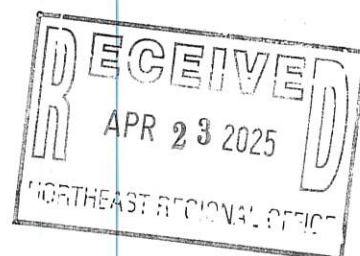


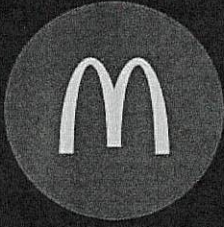
# Crocs

Mar 30 at 5:22 PM

# \$39.74

?

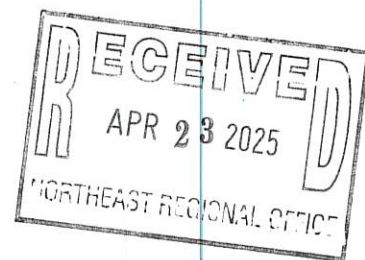




**McDonald's**

Apr 14 at 7:02 PM

**\$13.89**



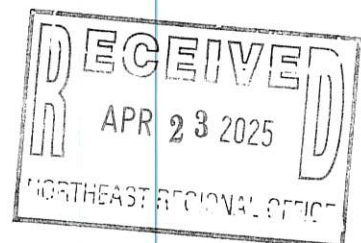




Trader Joe's

Apr 14 at 3:09 PM

\$136.01



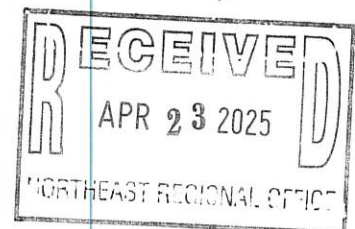




# Shoprite Howardpark S1

Mar 31 at 11:58 AM

# \$66.13

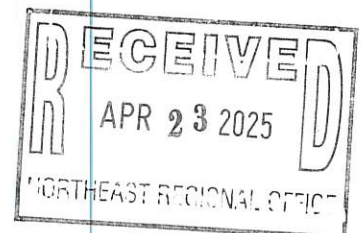




# Wegmans Owings Mills

Mar 27 at 6:18 PM

**\$169.86**



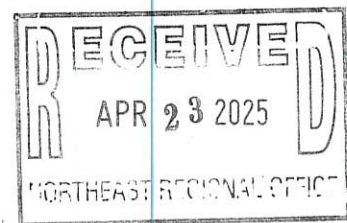




# Shoprite Howardpark S1

Wednesday at 6:10 PM

# \$44.98





# Harris Teeter 3 Whe

Saturday at 6:20 PM

# \$68.14

