Sample Asylum Fee Waiver (I-192)
for Adjusment of Status

TAHIRIH JUSTICE CENTER®

Protecting Immigrant Women and Girls Fleeing Violence

June 19, 2014

VIA USPS CERTIFIED MAIL; filed with I-485 application

Department of Homeland Security
US Citizenship and Immigration Services
Dallas Lockbox
P.O Box 660867
Dallas, TX 75266

Re: I-912 Fee Waiver for I-485 Asylee Application to Adjust Status
(A# [redacted]

Dear Sir/Madam:

Enclosed, please find Form I-912 Request for Fee Waiver. Mrs. [redacted] an asylee, is unable to pay the biometrics and filing fee for the I-485 Application to Register Permanent Residence or Adjust Status for herself and for her three children. The following documents are submitted in support of this fee waiver:

- Form G-28 Entry of Appearance as Accredited Representative
- Form I-912 Request for Fee Waiver and addendum
- Notice of Action from the Department of Social Services in indicating that [redacted] application for SNAP benefits for herself and her three children was reinstated and is valid from 07/01/2014 through 03/31/2015
- Notice of Action from the Department of Social Services in [redacted] indicating that [redacted] application for SNAP benefits for herself and her three children was approved and is valid from 04/22/2014 through 03/31/2015
- Copy of the Medicaid cards of [redacted] three children indicating that they have received Medicaid since 03/01/2013
- Letter from [redacted] Public Schools indicating that [redacted] three children [redacted] have been approved for free school meals

[redacted] and her three children currently reside in [redacted] a shelter for homeless families in [redacted]. [redacted] is currently unemployed, although she is actively searching for employment. She and her three children all receive SNAP. In addition, [redacted] three children also receive Medicaid and free school lunches.

6402 Arlington Blvd
Suite 300
Falls Church, VA 22042
Tel: 571-282-6161
Fax: 571-282-6162
TDD-VA Relay: 711
justice@tahirih.org
www.tahirih.org

Based on the above explanation and the attached evidence, I respectfully request that you please grant [redacted] and her three children a fee waiver for their applications to become Lawful Permanent Residents in the United States.

Thank you for your consideration of this application. Please do not hesitate to contact me by telephone at (571) 282-6175 or by e-mail at hillary@tahirih.org if you have any questions or concerns.

Sincerely,

Hillary Mellinger

Hillary Mellinger
BIA Accredited Representative
**partial accreditation, limited to DHS only*

Notice of Entry of Appearance as Attorney or Accredited Representative

Department of Homeland Security

DHS
Form G-28
OMB No. 1615-0105
Expires 02/29/2016

Part 1. Information About Attorney or Accredited Representative

Name and Address of Attorney or Accredited Representative

1.a. Family Name (*Last Name*): Mellinger

1.b. Given Name (*First Name*): Hillary

1.c. Middle Name: Allison

2. Name of Law Firm or Recognized Organization: Tahirih Justice Center

3. Name of Law Student or Law Graduate:

4. State Bar Number:

5.a. Street Number: 6402

5.b. Street Name: Arlington Boulevard

5.c. Apt. ☐ Ste. ☒ Flr. ☐ 300

5.d. City or Town: Falls Church

5.e. State: VA 5.f. Zip Code: 22042

5.g. Postal Code:

5.h. Province:

5.i. Country: United States

6. Daytime Phone Number (571) 282 - 6175

7. E-Mail Address of Attorney or Accredited Representative: hillary@tahirih.org

Part 2. Eligibility Information For Attorney or Accredited Representative

(Check applicable items(s) below)

1. ☐ I am an attorney eligible to practice law in, and a member in good standing of, the bar of the highest court(s) of the following State(s), possession(s), territory(ies), commonwealth(s), or the District of Columbia.

1.a.

1.b. I *(choose one)* ☐ *am not* ☐ *am* subject to any order of any court or administrative agency disbarring, suspending, enjoining, restraining, or otherwise restricting me in the practice of law. (If you are subject to any order(s), explain fully in the space below.)

1.b.1.

2. ☒ I am an accredited representative of the following qualified nonprofit religious, charitable, social service, or similar organization established in the United States, so recognized by the Department of Justice, Board of Immigration Appeals pursuant to 8 CFR 292.2. Provide the name of the organization and the expiration date of accreditation.

2.a. Name of Recognized Organization: Tahirih Justice Center

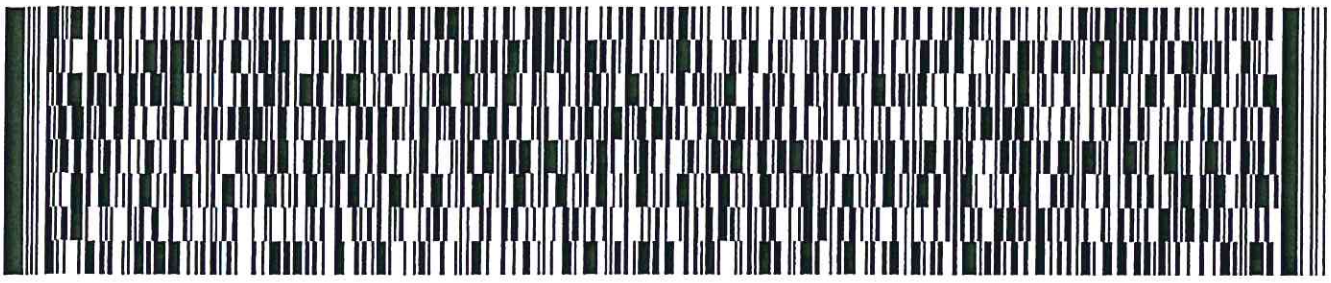
2.b. Date Accreditation expires *(mm/dd/yyyy)* ▶ 01/11/2016

3. ☐ I am associated with

3.a.

the attorney or accredited representative of record who previously filed Form G-28 in this case, and my appearance as an attorney or accredited representative is at his or her request. If you check this item, also complete **number 1 (1.a. - 1.b.1.) or number 2 (2.a. - 2.b.)** in **Part 2** *(whichever is appropriate).*

4. ☐ I am a law student or law graduate working under the direct supervision of the attorney or accredited representative of record on this form in accordance with the requirements in 8 CFR 292.1(a)(2)(iv).



Part 3. Notice of Appearance as Attorney or Accredited Representative

This appearance relates to immigration matters before (select one):

1. ☐ USCIS - List the form number(s)

1.a.

2. ☐ ICE - List the specific matter in which appearance is entered

2.a.

3. ☐ CBP - List the specific matter in which appearance is entered

3.a.

I hereby enter my appearance as attorney or accredited representative at the request of:

4. **Select only one:** ☒ Applicant ☐ Petitioner ☐ Respondent (ICE, CBP)

Name of Applicant, Petitioner, or Respondent

5.a. Family Name *(Last Name)*

5.b. Given Name *(First Name)*

5.c. Middle Name

5.d. Name of Company or Organization, if applicable

n/a

NOTE: Provide the mailing address of Petitioner, Applicant,or Respondent and not the address of the attorney or accredited representative, **except when a safe mailing address is permitted** on an application or petition filed with Form G-28.

6.a. Street Number and Name: 10402 Arlington Blvd. *

6.b. Apt. ☐ Ste. ☒ Flr. ☐ 300

6.c. City or Town: Falls Church

6.d. State: VA 6.e. Zip Code: 22042

7. Provide A-Number and/or Receipt Number

Pursuant to the Privacy Act of 1974 and DHS policy, I hereby consent to the disclosure to the named Attorney or Accredited Representative of any record pertaining to me that appears in any system of records of USCIS, ICE, or CBP.

8.a. Signature of Applicant, Petitioner, or Respondent

8.b. Date *(mm/dd/yyyy)* ▶ 5/9/2014

Part 4. Signature of Attorney or Accredited Representative

I have read and understand the regulations and conditions contained in 8 CFR 103.2 and 292 governing appearances and representation before the Department of Homeland Security. I declare under penalty of perjury under the laws of the United States that the information I have provided on this form is true and correct.

1. Signature of Attorney or Accredited Representative: Hillary Mellinger

2. Signature of Law Student or Law Graduate

3. Date *(mm/dd/yyyy)* ▶ 05/09/2014

Part 5. Additional Information

1. * I currently reside in a shelter and do not have a safe mailing address. Please send all correspondence to:
c/o Hillary Mellinger
Tahirih Justice Center
10402 Arlington Blvd. Ste. 300
Falls Church, VA 22042

Sample Asylum Fee Waiver (I-192) for AOS

Request for Fee Waiver

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-912
OMB No. 1615-0116
Expires 05/31/2015

►**Before you fill out this form, please read the instructions.**

FOR USCIS USE ONLY

Application Receipted At *(check only one box):*

USCIS Field Office

☐ Fee Waiver Approved
Date:_____

☐ Fee Waiver Denied
Date:_____

USCIS Service Center

☐ Fee Waiver Approved
Date:_____

☐ Fee Waiver Denied
Date:_____

Section 1. Information About You *(Provide information about yourself. If you are applying for a minor child, provide information about the minor child.)*

Line 1. a. Family Name (Last Name)

Line 1. b. Given Name (First Name)

Line 1. c. Middle Initial

Line 2. Alien Registration Number ► A-

Line 3. Date of Birth *(mm/dd/yyyy)* ►

Line 4. Marital Status ☐ Never Married ☐ Divorced ☐ Marriage Annulled ☒ Married ☐ Widow(er) ☐ Legally Separated

Line 5. Applications and Petitions (Enter the form number(s) of the application(s) and/or petition(s) for which you are requesting a fee waiver.)

Biometrics services fees, where applicable, will be included in the fee waiver request.

I-485

Section 2. Additional Information for Dependent(s)

Line 6. Complete the Table below if applicable. *(If you need more space, attach a separate sheet of paper.)*

Name (First, MI, Last)	A-Number (If applicable)	Is Individual Included in Fee Waiver Request?	Date of Birth *(mm/dd/yyyy)*	Relationship to You
	A-	☒ Yes ☐ No		Daughter
	A-	☒ Yes ☐ No		Son
	A-	☒ Yes ☐ No		Son
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		

Section 3. Basis for Your Request *(Check any that apply. For additional information, see the form instructions.)*

Line 7. a. ☒ I am or a relevant member of my household is currently receiving a means-tested benefit. *(Complete Sections 4 and 7.)*

Line 7. b. ☒ My household income is at or below 150% of the Federal Poverty Guidelines. *(Complete Sections 5 and 7.)*

Line 7. c. ☒ I have a financial hardship. *(Complete Sections 5, 6 and 7.)*

Section 4. Means-Tested Benefit

Line 8. **Complete the Table Below** *(If you need more space, attach a separate sheet of paper.)*

Name of Person Receiving the Benefit	Name of Agency Awarding Benefit	Date Benefit Was Awarded	Is This Benefit Being Received Now?
	Dept. of Social Services	04/22/2014	☒ Yes ☐ No
	City Public Schools	10/15/2013	☒ Yes ☐ No
	Dept. of Social Services	04/22/2014	☒ Yes ☐ No
	City Public Schools	10/15/2013	☒ Yes ☐ No
	Dept. of Social Services	04/22/2014	☒ Yes ☐ No
	City Public Schools	10/15/2013	☒ Yes ☐ No
	Dept. of Social Services	04/22/2014	☒ Yes ☐ No
See Addendum			☐ Yes ☐ No

Section 5. Household Income *(Provide evidence of monthly income or other support.)*

Line 9. Other than you, how many others in your household depend on the stated income? ▶ 3

(round to the nearest dollar)

Line 10. Average monthly wage income from household members ▶ $0.00

Line 11. Enter other money received each month that is not included in **Line 14.** (This could include spousal support, child support, unemployment, etc.) ▶ $0.00

TOTAL (USCIS will compare this amount to Federal Poverty Guidelines) ▶ $0.00

Section 6. Financial Hardship

Line 12. Describe your particular situation. Be sure to include how this situation has caused you to incur costs (and what the costs were) or loss of income that you have experienced (and what that loss was). Complete this section in English; otherwise, provide an accompanying English translation. *(If you need more space, attach a separate sheet of paper.)*

I and my three minor children are currently living in _ , a shelter for homeless families. I am not currently employed, but am actively looking for a job. All of mine and my three children's housing, clothing, and food needs are currently met by the shelter. At this moment in time, I do not have sufficient resources to pay for the I-485 filing fee for myself and my three children. I am actively searching for employment and a more permanent housing situation for my family. Thank you for your consideration of my fee waiver request.

If you are currently unemployed, you must complete Lines 13 and 14.

Line 13. Date that you became unemployed *(mm/dd/yyyy)* ▶ 03/01/2014

Line 14. Amount of unemployment compensation (monthly) that you are receiving (enter dollars) $0.00

Line 15. List your assets and the value of your assets. *(If you need more space, attach a separate sheet of paper.)*

Type of Asset	Value (enter dollars)
None	$0.00
TOTAL Value of Assets	$0.00

Section 6. Financial Hardship *(Cont'd)*

Line 16. List your average monthly costs, and provide evidence of monthly payments where possible. *(If you need more space, attach a separate sheet of paper.)*

Type of Cost	Value (Enter Dollars)	Type of Cost	Value (Enter Dollars)
Rent	$0.00	Loan Payment	$0.00
Mortgage	$0.00	Commuting Costs	$0.00
Food	$0.00	Medical	$0.00
Utilities	$0.00	School	$0.00
Child/Elder Care	$0.00	Other Expenses	$0.00
Insurance	$0.00	**TOTAL Monthly Costs**	$0.00

Section 7. Your Signature and Authorization

Do not sign your Form I-912 until it is complete and you are ready to file.

I take full responsibility for the accuracy of all the information provided, including all supporting documentation. I authorize the release of any information, including the release of my Federal tax returns, that USCIS needs to determine my eligibility.

Each person applying for a fee waiver request must sign Form I-912. This includes individuals identified in Sections 1 and 2 if 14 years of age or older. ***(If you need more space, attach a separate sheet of paper.)***

Line 17. Your Signature [redacted] Date *(mm/dd/yyyy)* ▶ 6/9/2014

Printed Name [redacted]

Line 17.1. Additional Signature [redacted] Date *(mm/dd/yyyy)* ▶ 6/9/2014

Printed Name [redacted]

Line 17.2. Additional Signature [redacted] Date *(mm/dd/yyyy)* ▶ 6/9/2014

Printed Name [redacted] *on behalf of minor son under 14 yrs. of age

Line 17.3. Additional Signature [redacted] Date *(mm/dd/yyyy)* ▶ 6/9/2014

Printed Name [redacted] *on behalf of minor son under 14 yrs. of age

Line 17.4. Additional Signature [redacted] Date *(mm/dd/yyyy)* ▶

Printed Name [redacted]

Section 7. Your Signature and Authorization *(continued)*

Line 17.5. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.6. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.7. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

(A)

FORM I-912 REQUEST FOR FEE WAIVER

Section 4. Means-Tested Benefit

Line. 8. Complete the Table Below *(If you need more space, attach a separate sheet of paper)*.

Name of Person Receiving the Benefit	Name of Agency Awarding Benefit	Date Benefit Was Awarded	Is This Benefit Being Received Now?
	Medicaid	03/01/2013	Yes
	Medicaid	03/01/2013	Yes
	Medicaid	03/01/2013	Yes

IMPORTANT INFORMATION ABOUT YOUR CASE/BENEFITS
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
NOTICE OF ACTION

DEPARTMENT OF SOCIAL SERVICES

Date of Notice:
Case Name:
Case Number:
Worker Name:
Worker Number:
Telephone No.:

ALEXANDRIA, VA 22301

1. What is happening to your SNAP benefits?

Your SNAP benefits will be REINSTATED effective 07/01/2014. Your payment is being reinstated because you have provided the information needed to continue assistance to your family or satisfied a requirement. You have been found eligible to receive benefits from 07/01/2014 through 03/31/2015.

2. What is the amount of your SNAP Benefits?

You will get:
$632.00 for July 2014 for 04 person(s).

Your SNAP Benefits are based on:

Gross Monthly Income	$0.00
Monthly Benefits	$632.00
Less Benefits Reduction	- $0.00
Total SNAP Benefits	= $632.00

Your benefits will be on your EBT card the 9th of each month.

3. What can you do if you have questions about the amount of SNAP benefits you are receiving?

If you have questions, call your worker. If you disagree with the action we have taken or the amount of SNAP benefits you are receiving, you can have an appeal hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake. The hearing officer will decide if we were right or wrong.

4. When must you ask for an appeal hearing?

You must ask for the hearing within 90 days of when you receive this Notice.

5. How do you ask for an appeal hearing?

Call your worker or 1-800-552-3431, OR

Mail an appeal request to: DSS, 801 E. Main St. Richmond,VA 23219-2901, ATTN: Appeals, OR

Fax an appeal request to DSS at 804-726-7656

6. Can you get free legal help?

Yes. Call Legal Aid toll free (1-866-534-5243) to get free legal advice or someone to represent you in your case.

7. Additional Information

You selected as head of household. If all adult members do not agree, contact your worker within 10 days.

You must report a change in your household income if the total amount goes above $2552.00. You must report this change no later than the 10th day of the month after the change occurs. You may also tell us if your income goes down which may increase your SNAP benefits. You may call us collect to report changes.

If you have children in public school they may be eligible for free meals. For more information contact the school.

IMPORTANT INFORMATION ABOUT YOUR CASE/BENEFITS
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
NOTICE OF ACTION

Date of Notice: 05/23/2014
Case Name:
Case Number:
Worker Name:
Worker Number:
Telephone No.:

1. Has your SNAP application been approved?

Yes, your application dated 04/22/2014 has been APPROVED.

You have been found eligible to receive benefits from 04/22/2014 through 03/31/2015.

2. What is the amount of your SNAP Benefits?

You will get:
$189.00 for April 2014 for 04 person(s).

Your SNAP Benefits are based on:

Gross Monthly Income	$0.00
Monthly Benefits	$189.00
Less Benefits Reduction	- $0.00
Total SNAP Benefits	= $189.00

3. What can you do if you have questions about the amount of SNAP benefits you are receiving?

If you have questions, call your worker. If you disagree with our decision you can ask for an appeal hearing. At the hearing, we must tell a hearing officer how we determined your SNAP benefits. You will have a chance to say why you think we made a mistake. The hearing officer will decide if we were right or wrong.

4. When must you ask for an appeal hearing?

You must ask for the hearing within 90 days of when you receive this Notice.

5. How do you ask for an appeal hearing?

Call your worker or 1-800-552-3431, OR

Mail an appeal request to: DSS, 801 E. Main St. Richmond, VA 23219-2901, ATTN: Appeals, OR

Fax an appeal request to DSS at 804-726-7656

6. Can you get free legal help?

Yes. Call Legal Aid toll free (1-866-534-5243) to get free legal advice or someone to represent you in your case.

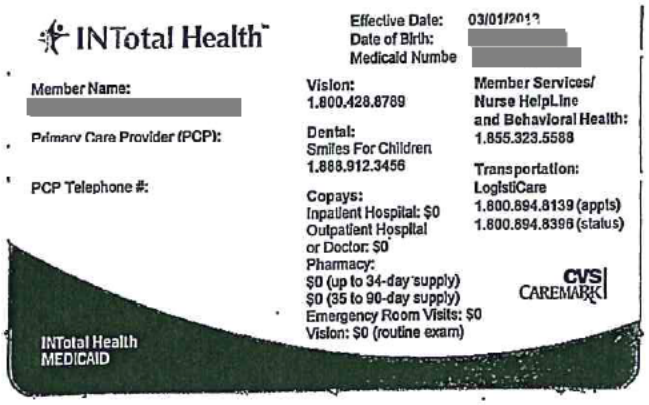
7. Additional Information

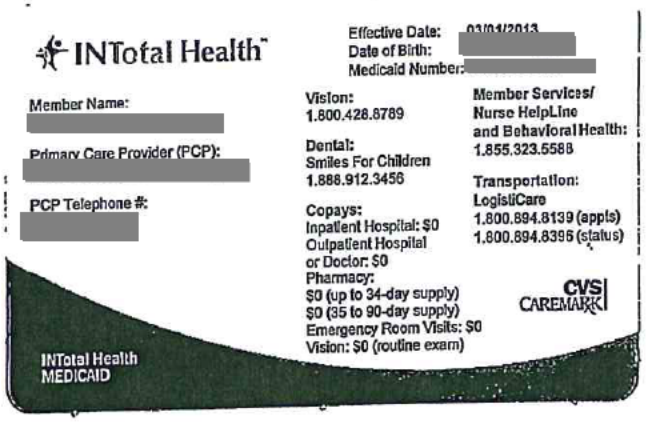
You selected as head of your SNAP household. If all adult members do not agree, contact your worker within 10 days.

If you applied for SNAP and TANF or General Relief (GR) at the same time and are approved for TANF or GR benefits, your SNAP benefits may be reduced without us having to give you advance notice.

You must report a change in your household income if the total amount goes above $2552.00 . You must report this change no later than the 10th day of the month after the change occurs. You may also tell us if your income goes down which may increase your SNAP benefits. You may call us collect to report changes.

If you have children in public school, they may be eligible for free meals. Contact the school for more information.


INTotal Health
Effective Date: 03/01/2013
Date of Birth:
Medicaid Numbe
Member Name:
Primary Care Provider (PCP):
PCP Telephone #:
Vision:
1.800.428.8789
Dental:
Smiles For Children
1.888.912.3456
Copays:
Inpatient Hospital: $0
Outpatient Hospital
or Doctor: $0
Pharmacy:
$0 (up to 34-day supply)
$0 (35 to 90-day supply)
Emergency Room Visits: $0
Vision: $0 (routine exam)
Member Services/
Nurse HelpLine
and Behavioral Health:
1.855.323.5588
Transportation:
LogistiCare
1.800.894.8139 (appts)
1.800.894.8396 (status)
CVS CAREMARK
INTotal Health
MEDICAID


INTotal Health
Effective Date: 03/01/2013
Date of Birth:
Medicaid Number:
Member Name:
Primary Care Provider (PCP):
PCP Telephone #:
Vision:
1.800.428.8789
Dental:
Smiles For Children
1.888.912.3456
Copays:
Inpatient Hospital: $0
Outpatient Hospital
or Doctor: $0
Pharmacy:
$0 (up to 34-day supply)
$0 (35 to 90-day supply)
Emergency Room Visits: $0
Vision: $0 (routine exam)
Member Services/
Nurse HelpLine
and Behavioral Health:
1.855.323.5588
Transportation:
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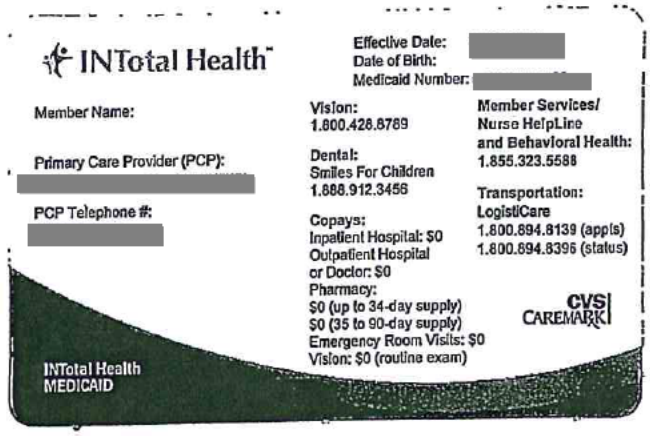
CVS CAREMARK
INTotal Health
MEDICAID


INTotal Health
Effective Date:
Date of Birth:
Medicaid Number:
Member Name:
Primary Care Provider (PCP):
PCP Telephone #:
Vision:
1.800.428.8789
Dental:
Smiles For Children
1.888.912.3456
Copays:
Inpatient Hospital: $0
Outpatient Hospital
or Doctor: $0
Pharmacy:
$0 (up to 34-day supply)
$0 (35 to 90-day supply)
Emergency Room Visits: $0
Vision: $0 (routine exam)
Member Services/
Nurse HelpLine
and Behavioral Health:
1.855.323.5588
Transportation:
LogistiCare
1.800.894.8139 (appts)
1.800.894.8396 (status)
CVS CAREMARK
INTotal Health
MEDICAID

[redacted] City Public Schools
[redacted]

10/15/2013 Application # [redacted]

Parent Notification of Eligibility - School Year 2013-2014

Dear parents of .

Your family application for free and reduced price meals has been processed for

Child Name	PIN	Student ID

Your child(ren) are: **Approved for free meals** (Income)

If you do not agree with the decision, you may discuss it with School Nutrition Services at [redacted]. If you wish to review the decision further, you have the right to a fair hearing. This can be done by calling or writing the following official: Tammy Ignacio, Assistant to the Superintendent, [redacted] Phone: [redacted]

You may reapply for benefits at any time during the school year, if your circumstances change. If you are not eligible now but have a decrease in household income, become unemployed, have an increase in household size, or get Supplemental Nutrition Assistance Program (SNAP) benefits (formerly the Food Stamp Program), or [redacted] Temporary Assistance for Needy Families (TANF) for your child, then fill out another application. Additional documentation required.

Meal prices for the 2013-2014 school year are: $1.75 for breakfast; elementary lunch: $2.45; secondary lunch: $2.65. A l a Carte items are additional.

Students living in the household who are not listed above may also be eligible for meal benefits. Please call: [redacted]

SAVE THIS LETTER to show as PROOF for other school benefits

Sincerely,

[redacted]
Director of School Nutrition Services
[redacted]

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

*** Save this Letter ***

See Reverse Side For Easy Opening Instructions

[redacted] City Public Schools
[redacted]

U.S. POSTAGE PITNEY
ZIP 22311 $ 000
02 1W
0001381808 OCT. 16

To the parents of

[redacted]

2291283473