016.20.96--010

Arkansas Department of Human Services
Division of County Operations

Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
TDD (501) 682-8275

April 15, 1996

The Honorable Sharon Priest
Secretary of State
State Capitol Building - Room 256
Little Rock, AR 72201

Dear Ms. Priest:

We are requesting regular APA promulgation for the enclosed revised form DCO-285, Food Stamp Quarterly Reporting. This form is used to report changes by selected Food Stamp participants who are subject to the quarterly reporting requirement.

Arkansas has been granted approval from the Department of Agriculture, Food and Consumer Services, to operate a demonstration project to assess the effectiveness of quarterly reporting in the Food Stamp Program.

Please call me at 682-8375 if you have a question about this rule.

Sincerely,

Roy Hart
Director

RH:RK:QC/bid

Enclosures

cc: file

BY _____

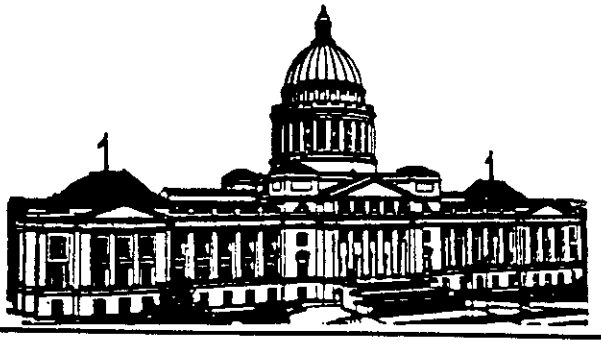
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS

96 APR 15 AM 11:39

AR. REGISTER DIV.
FILED

ARKANSAS REGISTER

Transmittal Sheet



Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 5/1/96 Code Number 016.20.96--010

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Roy Kindle, Jr. Phone 682-8251

Statutory Authority for Promulgating Rules Department of Agriculture, Food and Consumer Services, under CFR 272.3 (c)

		Date
Intended Effective Date	Legal Notice Published	03/13/1996
☐ Emergency	Final Date for Public Comment	04/11/1996
☐ 10 Days After Filing	Filed With Legislative Council.	03/13/1996
☒ Other	Reviewed by Legislative Council	04/04/1996
May 1, 1996	Adopted by State Agency	May 1, 1996

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

682-8375
Phone Number

Director
Title

4/12/96
Date

FILED
AR. CODE/STE. DIV.
96 APR 15 AM 11:39
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

☐ Policy ☒ Form ☐ Policy Directive

Issuance Number FSC 96-7

Food Stamp Certification Forms Manual

Issuance Date 5-1-96

From: Roy Hart
Director

Expiration Date Until Superseded

Subj: Food Stamp Quarterly Report (DCO-285)

Forms to be Deleted,	Dated	Forms to be Added,	Dated
DCO-285	3/95	DCO-285	3/96

Summary of Changes

The county office's return address will now print directly on the BRM envelope. Only two addresses, the customer's address and the return address, will appear on the envelope to be mailed to the customer.

Page 1

1. Changed the instructions for entering the names of all household members.
2. Added a section to be completed when a household member leaves.

Page 2

1. Deleted section where QR households were required to list their pay checks.
2. Added a section to be completed when a household member loses a job.
3. Added a section to be completed when a household member stops receiving unearned income of some type.

Page 3

1. Added a question about selling or trading in vehicles.
2. Added a statement about providing proof of actual utility costs.
3. Added a place to enter the date the household began paying dependent care costs.
4. Added a statement under *Medical Costs* to clarify that the household may provide a list of prescription drugs.

Page 4

1. Added a section to be used to report child support payments.
2. Moved information about hearings and civil rights complaints to the back to the of the outer envelope.

Inquires to: Betty Helmbeck, Food Stamp Section, 682-8284

Arkansas Human Services Food Stamp Quarterly Report

This is your Food Stamp Quarterly Report form. Please complete this form, sign it, and return it to the Department of Human Services (DHS) County Office in the enclosed envelope. If you need help filling out the form, call the County Office and ask for help. We will use the information you report on the form to see if your household is still eligible for food stamps. Please return this form as quickly as possible.

YOUR FOOD STAMP CASE NUMBER IS

IF YOU RETURN THIS FORM AFTER

YOUR FOOD STAMPS MAY BE DELAYED FOR

YOUR FOOD STAMP CASE WILL CLOSE
IF YOU DO NOT RETURN THIS FORM BY

IF YOUR CASE CLOSES, YOU MUST SUBMIT A NEW APPLICATION BEFORE YOU CAN PARTICIPATE IN THE FOOD STAMP PROGRAM.

YOUR ADDRESS

Have you moved from this address? ☐YES NO☐
Is the address shown correct? ☐YES NO☐
If you have moved or the address shown is not correct, complete the information below.

If you have moved, enter directions to your home if you now live on a rural route, use a post office box or use an address other than the one for the location where you live.

Street or Rural Route or P.O. Box

Apartment or Lot Number

City State

Zip Code New Phone Number

List your name and birth date and the names and birth dates of the people who live with you. Use a blank sheet of paper if you need more room to list all household members. Complete the information in the gray area only for new born babies and people who have moved into your home since your last report

Name	Birth Date	Does this person buy food & prepare meals separate from other household members?	Social Security Number	Relationship To You	Citizenship: U.S. Citizen	Legal Alien	Other
		YES ☐ NO ☐					
		YES ☐ NO ☐					
		YES ☐ NO ☐					
		YES ☐ NO ☐					
		YES ☐ NO ☐					
		YES ☐ NO ☐					

If a household member has died or left your home since your last report, complete this section. Use a blank sheet of paper if you need more room. Under "What Happened", please tell briefly why the person left your home. For example, if someone moved out, you may write "moved".

Name	Date Left	What Happened?

REPORT ALL INCOME FROM WORK HERE.

PART I - Provide information below about each person (including yourself) in your household who works. Use extra paper if more than two people in your household work.

Person's name _____
Where do they work?_____
Did they begin this job in the last three months?
___ YES ___ NO
If yes, when did the job start?

_____
Month Day Year

Person's name _____
Where do they work?_____
Did they begin this job in the last three months?
___ YES ___ NO
If yes, when did the job start?

_____
Month Day Year

Complete the following information if you or anyone else in the household got laid off, quit a job, got fired, went on sick leave or retired from any job in the last three months.

Person's Name _____ Employer/Company _____
Last Day of Work _____ Reason for Leaving Job _____

YOU MUST SEND PROOF OF ALL EARNED INCOME RECEIVED BY PEOPLE IN YOUR HOUSEHOLD. You may send: 1) a check stub for each pay check received in the last 30 days; or 2) a statement from the employer showing date of pay and gross amount of all checks (or cash) received in the last 30 days. Or, take this form to the employer to have PART II below completed. *NOTE: YOU MAY SEND PROOF OF INCOME FOR THE LAST SIX WEEKS. THIS WILL HELP US FIGURE YOUR INCOME BETTER. If anyone has stopped working, you must verify the last date of work, the amount of the last pay check and when it was received.*

PART II (Completed by employer, if necessary)

Employee Name _____

Rate of Pay $_____ per _____

Employee is paid

	Pay Day	Gross Earned (before deductions)
☐ Weekly		$
☐ Every 2 Weeks		$
☐ Twice Monthly		$
☐ Monthly		$
☐ Other_____		$

_____
Employer/Payroll Clerk Signature Date Telephone

Employee Name _____

Rate of Pay $_____ per _____

Employee is paid

	Pay Day	Gross Earned (before deductions)
☐ Weekly		$
☐ Every 2 Weeks		$
☐ Twice Monthly		$
☐ Monthly		$
☐ Other_____		$

_____
Employer/Payroll Clerk Signature Date Telephone

REPORT ALL INCOME OTHER THAN INCOME FROM WORK HERE. List all checks/money currently received by you or any other household member. Examples- AFDC, Social Security, SSI, VA, unemployment benefits, worker's compensation, child support, military allotments, contributions, yard work, maid work, interest, dividends, pensions, student grants, and loans, etc. Use an extra sheet of paper if necessary.

Name of Person Who Gets This Income	Source of This Income (List agency or person)	Amount of Income	How Often Is Income Received? (Monthly, weekly, etc.)	Check here if this income started in the last 3 months
		$		
		$		
		$		

If any income listed above has changed by more than $25 since your last application or report, you must provide proof of the new income amount. *(We have proof of AFDC payments. In most cases, we also have proof of SSI benefits and Arkansas unemployment benefits.)* We can accept as proof an award letter or other correspondence from the person/agency who provides the income. We may also be able to accept other documentation which shows your current income amount.

If your income or that of any other household member stopped in the last 3 months, complete the following questions. Also, provide proof of when the income stopped.

Name of person with Income_____ Source of income that stopped _____ Date Stopped _____

RESOURCES

You must tell us if the total amount of money that the members of your household have in cash, savings accounts, checking accounts, trust funds, and in stocks and bonds increases to more than $2,000. Enter the total amount here if it is more than $2,000. $_____

Report all new vehicles here. - List any cars, trucks, boats, vans, campers, and motorcycles or other licensed vehicles any household member has gotten since your last application or report. Use an extra sheet of paper if necessary.

1. Make _____ Model _____ Year _____ 2. Make _____ Model _____ Year _____

Did you or someone else in your household trade in or sell any vehicles? If yes, you may wish to report this below. It will help us figure your current resources. Make _____ Model _____ Year _____

SHELTER COSTS

You must report changes in your shelter costs only if you move. We may use your utility expenses to determine the amount of your food stamps.

Rent $ _____		Telephone (basic rate) $	_____
or		Electricity	_____
Mortgage Payment $ _____		Natural Gas	_____
		Wood	_____
(List real estate taxes and insurance costs only if they are not included in your mortgage payment.)		Butane	_____
		Water	_____
		Garbage/trash pickup	_____
		Sewer	_____
Real Estate Taxes $ _____		Initial Installation fee	_____
Homeowner Insurance $ _____		Other (list)	_____

You may choose either to use utility standards or to verify and use your actual utility costs. You may change from the utility standards to actual utility costs once in a 12 month period. You may also change from actual utility costs to the utility standard. (If you want to use actual utility costs, you must send proof of your current costs.)

Do you want to change? YES ☐ NO ☐ Call your caseworker if you want more information.

DEPENDENT CARE COSTS

If a member of your household began paying someone to care for a child (age 12 or younger) or a disabled household member (of any age) in order to work or attend school, please report the cost here. **Please list a phone number for the sitter or day care center:** _____ **Date Started** _____

Name of Babysitter/Day Care Center/Attendant	Amount Paid	Who Helps You Pay This Cost?	Is it to be paid daily, weekly, bi-weekly, or monthly?
_____	$ _____	_____	_____

MEDICAL COSTS

We can allow current medical expenses for all household members who are: (1) age 60 or older; or (2) receiving Supplemental Security Income (SSI) benefits; or (3) receiving Social Security disability payments; or (4) receiving VA benefits due to a total and permanent disability; or (5) receiving certain disability benefits from a state or federal agency. You may wish to report changes in medical expenses although you are not required to do so. **If you do report a change, you must provide proof of the change. We cannot consider medical expenses without proof.**

Service Provided	Amount	How often is each payment due?	Service Provided	Amount	How often is each payment due?
Medical and dental care	$		Dentures, hearing aids & eyeglasses	$	
Hospital or Nursing care	$				
Medicare/Medipak & other Health Insurance & medical payments	$		Services of an attendant or nurse	$	
			Transportation costs to get medical care	$	
Drugs prescribed by a doctor (Please provide a printout from your pharmacy or a list of the drugs you take.)	$		Other (explain)	$	
	$			$	
	$			$	
	$			$	

Please list name of household members that have these expenses.

CHILD SUPPORT

Are you or anyone else in your household paying child support to someone living outside your household?

☐YES ☐NO If yes, who pays? _____

To whom? Name _____ Telephone Number _____

Address _____

How much? $ _____ How often? _____

Are these payment court ordered? ☐YES ☐NO

Did the amount you are court ordered to pay change? ☐YES ☐NO

PROOF - You must show proof of the court order to pay child support and all payments that were made in the last three months. If you have given us proof of the court ordered amount, then you only have to provide proof of the payments for the last three months.

SOCIAL SECURITY NUMBERS

We must have a social security number for each household member. This is required by the Food Stamp Act of 1977, as amended by P.L. 97-98. Social security numbers are subject to verification by the Social Security Administration. They will be used to check the identity of household members, to prevent duplicate participation, and to facilitate mass changes. They may be used to select your household for a review or an audit. This may involve contacting your employer, bank or other parties.

PENALTY WARNING

Information on this form is subject to verification by federal, state and local officials and through the state Income and Eligibility Verification System and computer cross-matching with other Agencies. This information may also be submitted to the Immigration & Naturalization Service for verification. If information is found to be incorrect, your eligibility and benefit level may be affected, your food stamps may be stopped, and you may be subject to criminal prosecution for knowingly providing incorrect information.

- Do not give false information or hide information to get or continue to get food stamps.
- Do not trade or sell food stamps.
- Do not use food stamps to buy ineligible items such as alcoholic drinks and tobacco.
- Do not use someone else's food stamps for your household.

If you receive food stamps, you must follow the rules listed above. Any member of your household who intentionally breaks any of these rules can be disqualified from the Food Stamp Program for 6 months for the first violation, 12 months for the second violation, and permanently for the third violation; may be fined up to $250,000 or imprisoned for up to 20 years or both, and is subject to federal prosecution and penalties. Federal penalties include an additional disqualification period of 18 months, and, for second and subsequent felony convictions for Food Stamp Program fraud, a mandatory jail sentence.

Individuals found guilty in a federal, state, or local court of trading food stamps for controlled substances will be subject to disqualification for a period of 12 months for the first offense and permanently for the second offense. Individuals found guilty by a court of trading firearms, ammunition or explosives for food stamps will be subject to permanent disqualification for the first offense.

YOUR SIGNATURE (sign below)

My answers on this form are correct and complete to the best of my knowledge. I understand the penalties for hiding or giving false information. I understand I will owe the value of any extra food stamps I receive if I do not fully report changes in my household. To verify information contained in this report, I hereby authorize my employer(s), any banks, savings and loans, lending institutions, etc., and/or Federal or State agencies to release to DHS any information about me or my circumstances.

_____ _____

SIGN HERE TODAY'S DATE

TO OPEN-FOLD CAREFULLY AND TEAR ALONG PERFORATIONS

REMOVE THIS EDGE FIRST

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
LITTLE ROCK, AR
PERMIT NO. 1440

[redacted]

TO:

[redacted]

[redacted]

TO DETACH ENVELOPE PLEASE TEAR ALONG DOTTED LINE

TO SEAL - MOISTEN OTHER SIDE OF FLAP AND FOLD OVER.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

☐ Check here if you are reporting a new address.

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 2908 LITTLE ROCK, AR

POSTAGE WILL BE PAID BY ADDRESSEE

[redacted]

[redacted]

Did you remember to:

- ☐ List everyone in your home.
- ☐ Sign and date the form.
- ☐ Enclose your pay check stubs
  or
  Have your employer complete Part II on page 2.
- ☐ Report all changes in your household's situation.

If you need this material in a different format, such as large print, contact your local Department of Human Services (DHS) County Office.

HEARING

The information you provide on this form will be used to see if the amount of food stamps you receive must change. If there must be a change you will receive a notice explaining the change. If you do not agree with the action we take on your food stamp case you may have a hearing. You may ask for a hearing orally or in writing. To request a hearing orally you may call or go into the county office. Written requests may be given to the county office or sent directly to the following address:

Arkansas Department of Human Services
ATTN: Appeals & Hearings Section
P.O. Box 1437
Little Rock, AR 72203-1437

CIVIL RIGHTS

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin.

Arkansas Department of Human Services will not discriminate against any individual or group because of race, sex, religion, origin, color, marital status, handicap, or political beliefs. If you feel you have been a victim of discrimination because of race, sex, religion, age, national origin, color, marital status, handicap, or political belief, write immediately to:

Office of Equal Employment Opportunity
241 Donaghey Plaza South, Slot #203
P.O. Box 1437
Little Rock, AR 72203-1437
Telephone: (501) 682-6003
FAX: (501) 682-8926
TDD: (501) 682-7958

OR

Regional Director of Civil Rights
USDA, Food and Consumer Services
1100 Commerce Street, Room 5C-30
Dallas, TX 75242-1005
Telephone: (214) 767-0580
FAX: (214) 767-5522
TDD: Texas Relay Services
1-(800) 735-2988 or (214) 767-0241

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY HUMAN SERVICES

DIVISION COUNTY OPERATIONS

DIVISION DIRECTOR ROY HART

CONTACT PERSON BETTY HELMBECK

ADDRESS Donaghey Plaza South, P.O. Box 1437, Slot 1241, Little Rock, AR 72203-1437

PHONE NO. 682-8284

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?
   DCO-285, *Food Stamp Quarterly Report*

2. What is the subject of the proposed rule? Selected Food Stamp Program participants are subject to the quarterly reporting requirement. This form is used by these households to report changes.

3. Is this rule required to comply with federal statute or regulations? _____ YES __XX__ NO

   If yes, please provide the federal regulation and/or the statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? _____ YES __XX__ NO

   If yes, what is the effective date of the emergency rule? _____

   When does the rule expire? _____

   Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? __XX__ YES _____ NO

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? ____ YES __XX__ NO
   If yes, what is the effective date of the emergency rule? _____
   When does the rule expire? _____
   Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? ____ YES ____ NO

5. Is this a new rule? ____ YES __XX__ NO

   Does this repeal an existing rule? ____ YES __XX__ NO

   Is this an amendment to an existing rule? __XX__ YES ____ NO

   Is this an amendment to an existing rule? If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

6. What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

7. What is the purpose of this proposed rule? Why is it necessary? *These forms have been revised to comply with recent changes in the Food Stamp Program regulations.*

8. Will a public hearing be held on this proposed rule? ____ YES __XX__ NO

9. When does the public comment period end? April 15, 1996

10. What is the proposed effective date of this proposed rule? May 1, 1996

11. Do you expect this rule to be controversial? ____ YES __XX__ NO
    If yes, please explain.

12. Please give the names of persons, groups, or organizations which you expect to comment on these rules. Please provide their position (for or against) if known.

NAME	GROUP/ORGANIZATION	ADDRESS
David Manley, Attorney at Law	*Legal Services of Arkansas*	*400 W. Markham, Suite 700 Little Rock, AR 72201*

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

July 28, 1995

July 28, 1995

DEPARTMENT HUMAN SERVICES

DIVISION COUNTY OPERATIONS

PERSON COMPLETING THIS STATEMENT Betty Helmbeck

TELEPHONE NO. 682-8284 **FAX NO.** 682-1469

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionaire and proposed rules.

SHORT TITLE OF THIS RULE *DCO-285, Food Stamp Quarterly Report*

1. Does this proposed, amended, or repealed rule or regulation have a financial impact? ____ YES XX NO

2. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.
The proposed changes should not significantly increase the cost of printing or distributing the form.

3. If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.

1995-96 Fiscal Year		1996-97 Fiscal Year	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds	$	Cash Funds	$
Special Revenue	$	Special Revenue	$
Other	$	Other	$
Total	$	Total	$

4. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?

1995-96 Fiscal Year $ _____ 1996-97 Fiscal Year $ _____

5. What is the total estimated cost by fiscal year to the agency to implement this regulation?

1995-96 Fiscal Year $ _____ 1996-97 Fiscal Year $ _____