

ARKANSAS REGISTER

Transmittal Sheet



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

For Office Use Only: Effective Date 12/23/99 Code Number 016.20.99.029

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Roy D. Kindle, Jr. Phone 682-8251

Statutory Authority for Promulgating Rules The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
FSC 00-02 Date

Intended Effective Date	Legal Notice Published	<u>11-13-99</u>
<input type="checkbox"/> Emergency	Final Date for Public Comment	<u>12-12-99</u>
<input checked="" type="checkbox"/> 10 Days After Filing	Filed With Legislative Council	<u>11-12-99</u>
<input type="checkbox"/> Other	Reviewed by Legislative Council	_____
_____	Adopted by State Agency	<u>1-1-2000</u>

CERTIFICATION OF AUTHORIZED OFFICER

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

[Signature]
Signature
682-8375
Phone Number
Director
Title
11/4/99
Date

FILED
AR. REGISTER DIV.
99 DEC 13 PM 4:09
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
AMENDING LEGISLATIVE REGULATION
ARKANSAS LEGISLATIVE COUNCIL**

NUMBER AND TITLE: FSC 00-02, Food Stamp Application (DCO-220).

PROPOSED EFFECTIVE DATE: January 1, 2000

STATUTORY AUTHORITY: The Personal Responsibility and Work
Opportunity Reconciliation Act of 1996

NECESSITY AND FUNCTION: A statement has been added to the
application to advise food stamp applicants that failure to declare or (if requested) to
verify deductible expenses will be seen by the agency as a statement that the household
does not want to receive a deduction for this expense.

PAGES FILED: A total of 8 pages were filed.



**Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development**

PROMULGATION DATE: January 1, 2000

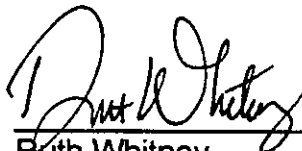
CONTACT PERSON: Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development
P.O. Box 1437, Slot 1220
Little Rock, AR 72203-1437

(501) 682-8251

NOTICE OF RULE MAKING

Pursuant to the Food Stamp Act of 1977 and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 a proposed revision to the Food Stamp Application (DCO-220). A statement has been added to the application to advise food stamp applicants that failure to declare or (if requested) to verify deductible expenses will be seen by the agency as a statement that the household does not want to receive a deduction for this expense.

Copies of the revised policy may be obtained by writing to the Division of County Operations, Attention: Food Stamp Policy Section, P. O. Box 1437, Slot 1241, Little Rock, AR 72203-1437. All comments must be submitted within 30 days of the date of publication of this notice. If you need any material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (Voice) or 682-8933 (TDD). 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 political affiliation, religion, disability, age, veteran status, sex, race, color or national origin.



Ruth Whitney

Director

Division of County Operations

**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 Ruth Whitney

CONTACT PERSON Roy D. Kindle, Jr.

ADDRESS Donaghey Plaza South, P.O. Box 1437, Slot 1220, Little Rock, AR 72203-1437

PHONE NO. (501) 682-8251

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?
FSC 00-02

- 2. What is the subject of the proposed rule?
The Food Stamp Application (DCO-220)

- 3. Is this rule required to comply with federal statute or regulations? XX YES NO
If yes, please provide the federal regulation and/or the statute citation.
The Food Stamp Act of 1977, as amended

- 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 NO
- Does this repeal an existing rule? YES NO
- Is this an amendment to an existing rule? 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. *NA*
7. What is the purpose of this proposed rule? Why is it necessary?
A statement has been added to the application to advise food stamp applicants that failure to declare or (if requested) to verify deductible expenses will be seen by the agency as a statement that the household does not want to receive a deduction for this expense.
8. Will a public hearing be held on this proposed rule? YES NO
9. When does the public comment period end? Dec. 12, 1999
10. What is the proposed effective date of this proposed rule Jan. 1, 2000
11. Do you expect this rule to be controversial?
 If yes, please explain. YES NO
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
<i>David Manley Attorney at Law</i>	<i>Legal Services of Arkansas</i>	<i>209 West Capitol Little Rock, AR 72203</i>

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

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 questionnaire and proposed rules.

SHORT TITLE OF THIS RULE FSC 99-21

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. *There are no changes in the way we operate the program. We have just added additional information to the application.*

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.

2000-2001 Fiscal Year		2001-2002 Fiscal Year	
General Revenue	\$ -0-	General Revenue	\$ -0-
Federal Funds	\$ -0-	Federal Funds	\$ -0-
Cash Funds	\$ -0-	Cash Funds	\$ -0-
Special Revenue	\$ -0-	Special Revenue	\$ -0-
Other	\$ -0-	Other	\$ -0-
Total	\$ -0-	Total	\$ -0-

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

2000-2001 Fiscal Year \$ -0- 2001-2002 Fiscal Year \$ -0-

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

2000-2001 Fiscal Year \$ -0- 2001-2002 Fiscal Year \$

BY _____
 SHARON FRIEST
 SECRETARY OF STATE
 STATE OF ARKANSAS

99 DEC 13 PM 4: 09

AR. REGISTER DIV.
FILED

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations



Policy
 Form
 Policy Directive

Issuance Number FSC 00-02

Food Stamp Certification Manual

Issuance Date 01-01-00

From: Ruth Whitney
 Director

Expiration Date Until
 Superseded

Subj: Food Stamp Application (DCO-220)

<u>Forms to be deleted</u>	<u>Dated</u>	<u>Forms to be added</u>	<u>Dated</u>
DCO-220	05-98	DCO-220	01-01-00

Summary of Changes

Pages 5 – A statement has been added to advise applicants that failure to report and/or to verify dependent care costs (if requested) is seen as a statement by the household that the household does not wish to receive a deduction for this cost.

Page 6 – A statement has been added to advise applicants that failure to report and/or to verify (if requested) any of the costs listed on this page is seen as a statement by the household that the household does not wish to receive a deduction for this cost.

Inquiries to: Betty Helmbeck, Food Stamp Section, (501) 682-8284

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IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE.

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
Food Stamp Application**

NAME	Social Security Number	Date of Birth
Mailing Address	City	State Zip Code
Signature	Today's Date	Your Telephone Number

INSTRUCTIONS

- ➊ To begin, enter at least your name, address and signature on this page, tear it off, and turn it in to the Department of Human Services (DHS) County Office. The date you turn your application in to the DHS County Office is your application date. If you are eligible, we must authorize your first food stamp benefits within 30 days from your application date. (NOTE: If you are applying under the SSI Prerelease Program, your application date is the date of your release from the institution.)
- ➋ Before we can find out if you are eligible for food stamp benefits, you must fill out pages 3-8 and turn them in. You may turn in these pages now or wait and turn them in later. Fill out as much of the information as you can. Let us know if you need help.
- ➌ You or a responsible member of your household must have an interview with a county office worker. Or, you may authorize someone who knows about your household to come to the interview. (All of the pages of your application must be turned in no later than the time of your interview.)
- ➍ **SOCIAL SECURITY NUMBERS** - You must give us a Social Security Number (SSN) for each household member. This is required by the Food Stamp Act of 1977, as amended by PL 97-98. SSNs are subject to verification and reviews or audits to assure your household is eligible for food stamp benefits. SSNs are used to check the identity of household members, to prevent duplicate participation and to facilitate mass changes. During this process, we may contact your employer, bank or other parties.
- ➎ You must furnish the following information:
 - ✓ Proof of your identity
 - ✓ Proof of your residency
 - ✓ Proof of liquid resources (checking and/or savings accounts, stocks, bonds, etc.) owned by you and all other household members
 - ✓ Proof of money (earnings, checks, contributions, cash, etc.) received by you and all other household members
 - ✓ Proof of medical costs for household members who are age 60 or older or who get certain types of disability payments
 - ✓ Proof of legal alien status for any household member who is not a U.S. citizen

➔ **IF YOU NEED FOOD STAMP BENEFITS RIGHT AWAY:** Food stamp benefits can be authorized for some eligible households within seven days of the date of their application. In order to find out if your household can get expedited service, we must have the entire application form. Complete the questions at the top of page 3, and then fill out as much of pages 3 through 8 as you can. Turn in the completed application as quickly as possible. Please let us know if you need help.

➔ **See the back of this page for more information.**

FOR COUNTY USE ONLY

IDENTITY		Date	RESIDENCE		Date
County _____	Reg.# _____	HH TYPE _____	EXPEDITED? <input type="checkbox"/> YES <input type="checkbox"/> NO	Denial Date _____	
Soc. Sec.# _____	HH SZ _____	Screeners _____	Date _____	Reason _____	Clt. Not. _____
Appl. Dt _____	Type _____	LD Date _____	Int. _____	Savings \$ _____	Type _____
BD Date _____	Wkr. # _____			Wkr. # _____	
Key Dt. _____	Op. Int. _____			Key Dt. _____	Op. Int. _____

FACTS ABOUT THE FOOD STAMP PROGRAM

The food stamp electronic benefits transfer (EBT) card is used like money to buy food. Most households will have to spend some of their own money along with the benefits on their food stamp EBT card to buy enough food for a month.

Your eligibility for food stamp benefits is based on the number of people in your household and your household's total income and resources such as bank accounts and vehicles. (Your household normally includes all the people who live with you, buy food with you and eat with you.) Your household's income and resources cannot be more than the program limits.

If your household is not eligible to get food stamp benefits, you will get a notice telling you why. If your household is eligible to get food stamp benefits, you will get an approval notice.



ARE YOU ENTITLED TO GET FOOD STAMP BENEFITS WITHIN SEVEN DAYS?



If your household is eligible to get food stamp benefits and meets one of the three conditions listed below, you may be able to get your food stamp benefits within seven days of your date of application.

- ① **Your gross monthly income is less than \$150, and your liquid resources total \$100 or less.** Income means money from work, money from checks or money people give you. We will count your income and the income of all other household members. Liquid resources are cash on hand, money in a checking or savings account, stocks, bonds, etc. We will count your resources and the resources of all other household members.
- ② **Your monthly shelter bills (rent or house payment and utilities) are more than your household's total gross income and liquid resources.**
- ③ **You are a migrant or a seasonal farm worker, and your household has little or no income.**

INFORMATION ABOUT YOUR APPEAL RIGHTS

If you are not happy with our actions or if we fail to act on your application, you or your representative may ask for a hearing. To ask for a hearing, call the DHS County Office, write a letter to the DHS County Office or go into the DHS County Office. You may also write to the address below:

Arkansas Department of Human Services
ATTN: Appeals and Hearings Section
P.O. Box 1437, Slot 1001
Little Rock, AR 72203-1437
Telephone - (501) 682-8622
TDD for Hearing Impaired - 1-800-285-6698
FAX - (501) 682-6605

The Food Stamp Program is available without regard to race, color, national origin, religion, sex, age, political belief, or physical or mental disability. If you feel we discriminated against you, you may send a complaint to the address below:

Office of Equal Opportunity
Donaghey Plaza South
103 East 7th
P.O. Box 1437, Slot 203
Little Rock, AR 72203-1437
Telephone - (501) 682-6003
TDD for Hearing Impaired - (501) 682-7958
FAX - (501) 682-8926

QUALITY ASSURANCE

Your case may be selected for a quality assurance (Q.A.) review. If so, there will be a review of the statements on this form. There will also be a review of how the county office handled your case. During this review, we may ask other people or agencies for information. Normally, we will ask your permission to get this information. You must cooperate during the Q.A. review.

ACCESSING YOUR FOOD STAMP BENEFITS

You will be provided with an electronic benefits transfer (EBT) card that looks like a credit card. You will use the EBT card at the grocery store to purchase your food. In Jefferson County, you will get the EBT card in the county office. In other counties, the EBT card will be mailed to you. You will be mailed a personal identification number (PIN). You must have the PIN to use the EBT card. If your EBT card is mailed to you, the PIN will be mailed in a separate envelope.

REPORTING CHANGES

All recipients of food stamp benefits must report certain changes in their circumstances. These changes are: 1) Changes in any source of income; 2) Changes of more than \$25 in gross monthly income; 3) Changes in household size; 4) Moving from one place to another; 5) Address changes; 6) Getting a new or used vehicle; and 7) Liquid resources of \$2,000 or more.

If your household is selected as a quarterly reporting household, you will be sent a report form every third month. If you receive only food stamp benefits, you will only need to report your changes on the quarterly report. IF YOU ALSO RECEIVE TEA CASH ASSISTANCE OR MEDICAID, YOU MUST CONTINUE TO REPORT YOUR CHANGES TO THE TEA CASE MANAGER AND/OR MEDICAID WORKER. WE WILL LET YOU KNOW IF THESE CHANGES WILL AFFECT YOUR FOOD STAMP CASE. You will get a pamphlet telling you exactly how to complete and submit your quarterly report.

If your household is not selected as a quarterly reporting household, you must report any change within 10 days of the day you learn of the change. You will be given a Change Report Form. It will explain exactly how and when to report changes. If you receive TEA Cash Assistance or Medicaid, any change you report may also affect your TEA or Medicaid case. We will let you know.

FOOD STAMP APPLICATION - PART II

NOTICE

If you miss your scheduled interview appointment, you will not be given a second appointment unless you request it.

NAME OF APPLICANT _____ **Social Security Number** _____

Mailing Address _____

City _____ **County** _____ **State** _____ **Zip** _____ **Telephone** _____

If you don't have a street address, tell us how to get to where you live. -

EXPEDITED SERVICE - Food stamp benefits for certain eligible households will be authorized within seven days of the date they file an application. The answers to the questions below will help us decide if you qualify for expedited service. Answer for yourself and all other household members.

1. Will your household's total income for this month be less than \$150? (Include money already received this month. Also, include money you expect to receive later this month.) YES NO
2. Does your household have \$100 or less in cash, checking accounts, savings accounts, etc.? YES NO
3. Is anyone in your household a migrant or seasonal farm worker? YES NO
If yes, answer questions A and B below.
 - A. Did your household's only income recently stop? YES NO
 - B. Do you or anyone else expect any income from a new source this month? YES NO

4. Enter your household's total monthly shelter costs. Do not include past due amounts.

- ◆ Current rent or mortgage payment. \$ _____
- ◆ Total current monthly utility costs. + _____
- ➔ **TOTAL SHELTER COSTS** \$ _____

Enter your household's total gross income and resources for this month. (This includes your income and resources, as well as the income and resources of all other household members.)

- ◆ Total Gross Income (Earnings & Other Income) \$ _____
- ◆ Cash on Hand + _____
- ◆ Money in the Bank + _____
- ➔ **TOTAL INCOME & RESOURCES** \$ _____

ARE YOUR HOUSEHOLD'S TOTAL SHELTER COSTS MORE THAN YOUR HOUSEHOLD'S TOTAL INCOME & RESOURCES? YES NO

HOUSEHOLD MEMBERS - LIST ALL THE PEOPLE WHO LIVE IN YOUR HOME. INCLUDE YOURSELF.

You must list all household members. If necessary, use the front page of another application or a separate sheet of paper to list everyone in your household. People age 21 or younger who live with a parent must be included in the same household as the parent.

Social Security Number	NAME (First, middle initial & last)	BIRTHDATE (Month, day & year)	Does this person buy food & prepare meals separate from the others? YES <input type="checkbox"/> NO <input type="checkbox"/>	Relationship to you	CITIZENSHIP			COUNTY USE	
					U.S. Citizen	Legal alien	Other	SSN CODE	Work REG
			YES <input type="checkbox"/> NO <input type="checkbox"/>						
			YES <input type="checkbox"/> NO <input type="checkbox"/>						
			YES <input type="checkbox"/> NO <input type="checkbox"/>						
			YES <input type="checkbox"/> NO <input type="checkbox"/>						
			YES <input type="checkbox"/> NO <input type="checkbox"/>						
			YES <input type="checkbox"/> NO <input type="checkbox"/>						

- 1 Do you or any other household member pay money for a room or meals to a person with whom you live? YES NO
- 2 Are you or any other household member age 60 or older and unable to shop for food or cook meals because of a disability? YES NO
- 3 Are you or any other household member participating in the Food Stamp Program in another place? YES NO
- 4 Are you or any other household member now disqualified, or have you or any other household member ever been disqualified, from the Food Stamp Program for providing incorrect information or for failing to provide information that affected food stamp eligibility and benefits? YES NO
- 5 Have you or any other household member been found guilty of or pled guilty or nolo contendere (no contest) to a felony offense involving the manufacture or distribution of a controlled substance? YES NO

AUTHORIZED REPRESENTATIVE

You can authorize someone outside your household to make an application for food stamp benefits for your household. You can authorize the same person or someone else to use your EBT card to buy food for your household. If you would like to authorize someone, write their name below.

Name	Name
Address	Address
Telephone	Telephone

STUDENT INFORMATION

Do you or any household member attend or have you applied for admission to an institution of higher education such as a college, vocational school, or any other training program beyond high school? YES NO

If yes, complete the following.

NAME OF STUDENT	SCHOOL OR PROGRAM	HOURS OF CLASS PER WEEK

- ① Have any students in your household received or applied for educational grants, loans, scholarships, veteran's benefits, etc.? YES NO If yes, list the benefits. _____
- ② Are the educational expenses of any of these students paid through Rehabilitation Services or JTPA (Job Training Partnership Act)? YES NO

HOUSEHOLD RESOURCES

FOR COUNTY USE

Complete this section for yourself, your children, and all other members of your household. Report all resources your household owns, is buying or has access to.

DO YOU HAVE?	YES	NO	OWNER'S NAME	Total Value	OTHER
Cash on hand and/or savings at home				\$	
Savings accounts/ Certificates of Deposit (CD) Credit Union Accounts				\$	Bank Name
Checking accounts				\$	Bank Name
Stocks, bonds, IRAs Keogh Plans, Mutual Funds				\$	
Cars and # 1 Licensed ? YES <input type="checkbox"/> NO <input type="checkbox"/>				\$	Make Model Year
Trucks # 2 Licensed ? YES <input type="checkbox"/> NO <input type="checkbox"/>				\$	Make Model Year
(Running or # 3 Licensed ? YES <input type="checkbox"/> NO <input type="checkbox"/> Not)				\$	Make Model Year
Recreational Vehicles (Boats & Motors, Campers, Motorcycles, three or four wheelers, etc.)				\$	Make Model Year
Real estate other than your home				\$	Location Amount Owed \$
Other (Prepaid burial plans, trust funds, etc.)				\$	Description -

➔ HAVE YOU OR ANYONE IN YOUR HOUSEHOLD SOLD, TRADED OR GIVEN AWAY ANYTHING OF VALUE IN THE LAST THREE MONTHS? YES NO IF YES, PLEASE USE THE SPACE BELOW TO TELL WHAT HAPPENED.

HOUSEHOLD INCOME - CASH, BENEFIT CHECKS, ETC.

1 Complete this section to tell us whether you or any member of your household receives any of the listed income.

SOURCE OF INCOME	Does any-one receive		IF YES, NAME OF PERSON WHO RECEIVES CHECK / PAYMENT	AMOUNT OF EACH CHECK OR PAYMENT	MOST RECENT DATE OF PAYMENT	HOW OFTEN RECEIVED? (weekly, monthly, etc.)
	Yes	No				
TEA Cash Assistance			1.	\$		
			2.	\$		
Social Security			1.	\$		
			2.	\$		
Supplemental Security Income (SSI)			1.	\$		
			2.	\$		
Veteran's Benefits (VA)			1.	\$		
			2.	\$		
Unemployment Compensation			1.	\$		
			2.	\$		
Railroad Retirement or Other Pensions			1.	\$		
			2.	\$		
Child Support/ Alimony			1.	\$		
			2.	\$		

2 Complete this section if you or any other household member has money or checks coming in from any of the income sources listed here - utility assistance payments, rental income, roomers, boarders, interest, dividends, royalties, mineral rights payments, contributions from friends and relatives, loans, prizes, gifts, payments from the sale of property you used to own, or any other unearned income.

State Source of Income	Name of Household Member Who Receives This Income	Amount of Each Check or Payment	How Often Received (weekly, monthly, etc.)
		\$	
		\$	
		\$	

3 Have you or anyone in your household recently applied to receive money from any source? YES NO
 IF YES, STATE TYPE OF BENEFIT _____ WHO APPLIED? _____

COUNTY USE ONLY

INCOME FROM WORK*Please Answer all questions.***1** Have you or anyone in your household quit a job in the last 60 days? YES NO

If yes, who? _____ Why? _____

Date of quit _____ Employer/Company _____

2 Are you or anyone in your household on strike? YES NO

If yes, who? _____ Employer/Company _____

Union _____ Date Strike Began _____

3 Have you or anyone in your household received any wages, salaries, tips or commissions from work this month? (This includes part-time jobs and odd jobs.) YES NO Do you or anyone in your household expect any wages, salaries, tips or commissions from work later this month? YES NO

Complete one section below for each job held by a household member. Attach a sheet of paper if you need more room.

Name _____

Name _____

Employer/Company _____

Employer/Company _____

How often paid? Choose one - Weekly Bi-Weekly
Monthly Other How often paid? Choose one - Weekly Bi-Weekly
Monthly Other

How much paid? \$ _____

How much paid? \$ _____

4 Are you or anyone in your household self-employed? YES NO

(This includes contract work.)

If yes, who? _____ What kind of business? _____

5 Are you or anyone in your household participating in a job training program? YES NO

If yes, who? _____ Name of program? _____

6 Are you or anyone currently in your household serving in the military? YES NO

(This includes National Guard and reserve units.)

If yes, who? _____ Monthly pay? \$ _____

7 Do you expect any changes in any job declared on this application? YES NO

If yes, explain what will change. _____

8 Do you or anyone in your household expect to start work at a new job? YES NO

If yes, who? _____ Where? _____ When? _____

DEPENDENT CARE COSTSDo you or anyone in your household pay someone to care for a child or a disabled or elderly adult so that a household member can work, attend training or school, or look for work? YES NO If yes, how much? \$ _____ How often? Choose one - Weekly Bi-weekly Monthly Other

Name of person or daycare center _____ Telephone number _____

Address _____

Does anyone help pay these costs? YES NO If yes, who? _____To receive a deduction for dependent care costs, you must report the expense and provide verification if requested. Failure to report or to verify dependent care costs, if requested, will be seen as a statement by your household that you do not want to receive a deduction for this expense.

County Use Only

Notice to Applicants – To receive a deduction for any of the expenses listed on this page, you must report the expense and provide verification, if requested. Failure to report or (if requested) to provide verification of any of these expenses will be seen as a statement by your household that you do not want to receive a deduction.

MEDICAL COSTS FOR AGED OR DISABLED MEMBERS

The current medical costs of anyone who is age 60 or older or who gets disability benefits are deductible. Please complete this section if you or anyone in your household is aged or gets disability benefits. List the current medical expenses of all household members (including yourself) who are age 60 or older. Also list the current medical expenses of household members who get Medicaid benefits based on total disability or who get one of the following checks based on total disability: Social Security, SSI, VA, Railroad Retirement, Civil Service or Government Retirement.

Name of Person With Expense	Type of Expense	Amount	How Often is Payment Due?
	PRESCRIPTION DRUGS	\$	
	MEDICARE	\$	
	MEDIPAK	\$	
	OTHER MEDICAL INSURANCE	\$	
	DOCTOR OR DENTIST FEES	\$	
	HOSPITAL OR NURSING CARE	\$	
	Other	\$	
	Other	\$	

EXAMPLES OF OTHER TYPES OF ALLOWABLE MEDICAL COSTS ARE LISTED BELOW.

1. Ambulance Costs
2. Attendants/ Home Health Aides
3. Chiropractic Services
4. Contact Lenses
5. Dentures
6. Eyeglasses
7. Hearing Aids
8. Needles & Syringes
9. Nursing Home Care
10. Surgery
11. Therapy
12. Transportation to get Medical Care
13. Wheel Chairs
14. Wheel Chair Ramps

THESE ARE ONLY EXAMPLES. LIST ANY MEDICAL EXPENSE.

Does anyone outside your household pay or help to pay any of the medical expenses listed above? YES NO

If yes, who helps? _____ What expenses do they help with? _____

SHELTER COSTS

List your household's current shelter costs. Do not list past due amounts.

EXPENSE	AMOUNT	EXPENSE	AMOUNT	County Use Only
Rent	\$	Electricity	\$	Entitled to Standard Yes <input type="checkbox"/> No <input type="checkbox"/> Elected Standard Yes <input type="checkbox"/> No <input type="checkbox"/>
Mortgage (House Payment)	\$	Natural Gas/Butane Gas	\$	
Property Tax (If not included with house payment)	\$	Wood	\$	
		Water/Sewer	\$	
Home Owner's Insurance (If not included with house payment)	\$	Garbage/Trash Pickup	\$	
Basic Rate for Telephone (Include tax on the basic fee)	\$	Utility Installation Charges/Other	\$	

The utility allowance is a standard amount we can use to represent your utility costs. The following questions will help us see if your household may elect to use the utility allowance.

- 1 How do you heat your home? _____ What kind of fuel do you use? _____
- 2 Do you use an air conditioner in the summer? YES NO 3 Do you live in a public housing project? YES NO
- 4 Do you share a gas or electric meter with another household? YES NO

CHILD SUPPORT PAYMENTS

List child support paid by a household member to someone outside the home.

Do you or anyone else in your home pay child support? YES NO

If yes, who pays? _____ To whom? Name - _____ Address - _____ Telephone Number : _____	Amount Paid \$ _____ How often? Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> (Choose one) Monthly <input type="checkbox"/> Other <input type="checkbox"/> Are these payments court ordered? YES <input type="checkbox"/> NO <input type="checkbox"/>	County Use
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PENALTIES	<p>Any member of your household who intentionally breaks any of the following rules will not be able to get food stamp benefits for one year. The second time a household member intentionally breaks one of these rules, he or she will not be able to get food stamp benefits for two years. The third time a household member intentionally breaks one of these rules, he or she will never again be allowed to get food stamp benefits.</p> <div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> ⚡ DO NOT GIVE FALSE INFORMATION OR WITHHOLD INFORMATION IN ORDER TO GET OR TO CONTINUE TO GET FOOD STAMP BENEFITS. ⚡ DO NOT ALTER ANY AUTHORIZATION DOCUMENT TO GET FOOD STAMP BENEFITS YOU ARE NOT ELIGIBLE TO RECEIVE. ⚡ DO NOT USE FOOD STAMP BENEFITS TO BUY NON-FOOD ITEMS LIKE ALCOHOLIC DRINKS, TOBACCO, OR PERSONAL GROOMING ITEMS. ⚡ DO NOT TRADE OR SELL FOOD STAMP BENEFITS OR ALLOW UNAUTHORIZED USE OF ELECTRONIC BENEFITS TRANSFER (EBT) CARDS. ⚡ DO NOT USE SOMEONE ELSE'S EBT CARD FOR YOUR HOUSEHOLD'S BENEFIT. </div> <ul style="list-style-type: none"> • ADDITIONAL PENALTIES--A court of law can ban anyone who intentionally breaks Food Stamp Program rules from getting food stamps for an additional 18 months. A court can also impose fines of up to \$250,000, or send the violator to jail for up to 20 years or both. • Any member of your household found to have made a fraudulent statement or representation about their identity or residence in order to get food stamp benefits in two locations during the same month will be barred from getting food stamp benefits for ten years. <p>NOTICE: THE FOLLOWING INDIVIDUALS ARE PERMANENTLY BANNED FROM PARTICIPATING IN THE FOOD STAMP PROGRAM:</p> <ul style="list-style-type: none"> • Violators found guilty in a court of law of buying or selling fire arms, ammunition, explosives, or controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for food stamp benefits • Violators convicted in a court of law of trafficking food stamp benefits in excess of \$500 • Fleeing felons and parole/probation violators • Individuals who were found guilty of or pled guilty or nolo contendere (no contest) to any state or federal offense classified as a felony by the law or jurisdiction involved, and which has as an element of the offense the distribution or manufacture of a controlled substance
WORK	<p>Under the Food Stamp Act, all non-exempt household members who are physically and mentally fit must register for work. <i>By your signature below, you are agreeing to work-register all non-exempt household members.</i> If any member of your household is subject to work registration you will receive a notice. The notice will tell you exactly which household members are subject to work registration.</p> <p>Food Stamp Program Requirement to Work - Unless exempt, people between the ages of 18 and 50 who receive food stamp benefits must meet the Requirement to Work.</p> <ul style="list-style-type: none"> • The following people are exempt from the Requirement to Work -- anyone medically certified as disabled, pregnant women, and parents with children age 18 or younger. Some people are not required to register for work because they are students, because they are drawing (or have applied for) Unemployment benefits, or they are caring for a disabled person. These people are exempt from the Requirement to Work so long as they are also exempt from being registered for work. • Anyone who is not exempt from the Requirement to Work must work at least 20 hours per week at a job or a self-employment enterprise or participate in and comply with a work program for at least 20 hours per week. These work programs are: a Job Training Partnership Act (JTPA) program, a Trade Adjustment Act (TRA) program, or a recognized refugee training program. In counties with a Food Stamp Employment and Training (E&T) Program, anyone who participates in the E&T Program, other than a job search component, at least 20 hours per week meets the Requirement to Work. In counties with a Workfare Program, anyone who participates in the Workfare Program meets the Requirement to Work. • Unless exempt, food stamp recipients who do not meet the Requirement to Work for any three months out of a 36 month period will be ineligible to receive food stamp benefits for the rest of the 36 month period or until they comply with the Requirement to Work.
HERITAGE	<p>We would like for you to indicate your racial or ethnic identity. Providing this information is optional and will not affect your eligibility for food stamp benefits. We are authorized by the Federal Civil Rights Act to collect this information. It will be used to insure that food stamp benefits are distributed fairly.</p> <p> <input type="checkbox"/> WHITE (not of Hispanic Origin) <input type="checkbox"/> AMERICAN INDIAN OR <input type="checkbox"/> HISPANIC <input type="checkbox"/> BLACK (not of Hispanic Origin) <input type="checkbox"/> ALASKAN NATIVE <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER </p>
SIGNATURE	<p>By my signature I authorize the Department of Human Services (DHS) to get information from other state agencies, banks and savings and loan institutions, employers, federal agencies, and other sources to prove (verify) my statements are true and correct. I understand that information may be verified by collateral contacts when differences are found by DHS between what I report and the information provided by the sources listed above. I further understand that this information may affect my household's eligibility for food stamp benefits and the amount of food stamp benefits I may receive.</p> <p>I understand the questions on this application, and the penalties for hiding information, giving false information or breaking any of the other rules listed above in the penalty section. I certify, under penalty of perjury, that my answers are correct and complete to the best of my knowledge and that all household members are either U.S. citizens or aliens with legal immigration status.</p> <p>Sign Here _____ Today's Date _____</p> <p>Witness if signed with an X → _____</p>
COUNTY USE ONLY	
PERSON INTERVIEWED: _____	HOUSEHOLD OR? YES <input type="checkbox"/> NO <input type="checkbox"/>
INTERVIEWED BY: _____	R&R PAMPHLET? YES <input type="checkbox"/> NO <input type="checkbox"/>
INTERVIEWED ON: _____	OR PAMPHLET? YES <input type="checkbox"/> NO <input type="checkbox"/>
	MEMBER WORK REG? YES <input type="checkbox"/> NO <input type="checkbox"/>
	WORK REG. NOTICE? YES <input type="checkbox"/> NO <input type="checkbox"/>