

**RENEWAL APPLICATION FOR AUXILIARY GRANT (AG), SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

This is an application to renew your eligibility for benefits. You may bring this application to the local Department of Social Services office or mail it to the local Department of Social Services office. You may also apply online for renewal for SNAP or TANF at <https://commonhelp.virginia.gov/access/>.

A. HOUSEHOLD INFORMATION

1. Your Contact Information

Your Name (last, first, middle initial) _____

Your Street Address (include apartment number) _____

City, State, ZIP _____

Your Mailing Address (if different from your street address) _____

City, State, ZIP _____

In what city or county do you live? _____

E-mail Address _____

Primary Telephone Number _____

Alternate Telephone Number _____

2. **Household Composition:** This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person.

1

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: Male Female

Marital Status: Married Never Married

Separated Divorced Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Are you a veteran or dependent? Yes No :

Program(s) Requested:

None AG SNAP TANF

Self

Relationship to You _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Are you a U.S. citizen? Yes No

If No, immigration status: _____

US Residency Date: ___/___/___

Alien Registration Number: _____

Are you disabled or pregnant? Yes No

Are you temporarily living away from home? Yes No

Date Left ___/___/___ **Expected Return Date** ___/___/___

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Racial Heritage: White Black/African American Asian Asian & Black/African American Asian & White

American Indian/Alaskan Native Black/African American & White American Indian/Alaskan Native & White

Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black Other/Unknown

2

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: Male Female

Marital Status: Married Never Married

Separated Divorced Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? Yes No :

Program(s) Requested:

None AG SNAP TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? Yes No

If No, immigration status: _____

US Residency Date: ___/___/___

Alien Registration Number: _____

Is this person disabled or pregnant? Yes No

Is this person temporarily away from home? Yes No

Date Left ___/___/___ **Expected Return Date** ___/___/___

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Racial Heritage: White Black/African American Asian Asian & Black/African American Asian & White

American Indian/Alaskan Native Black/African American & White American Indian/Alaskan Native & White

Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black Other/Unknown

Household Composition (continued)

If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

3

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: Male Female

Marital Status: Married Never Married

Separated Divorced Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? Yes No :

Program(s) Requested:

None AG SNAP TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? Yes No

If No, immigration status: _____

US Residency Date: ___/___/___

Alien Registration Number: _____

Is this person disabled or pregnant? Yes No

Is this person temporarily away from home? Yes No

Date Left ___/___/___ **Expected Return Date** ___/___/___

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Racial Heritage: White Black/African American Asian Asian & Black/African American Asian & White

American Indian/Alaskan Native Black/African American & White American Indian/Alaskan Native & White

Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black Other/Unknown

4

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: Male Female

Marital Status: Married Never Married

Separated Divorced Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? Yes No :

Program(s) Requested:

None AG SNAP TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? Yes No

If No, immigration status: _____

US Residency Date: ___/___/___

Alien Registration Number: _____

Is this person disabled or pregnant? Yes No

Is this person temporarily away from home? Yes No

Date Left ___/___/___ **Expected Return Date** ___/___/___

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Racial Heritage: White Black/African American Asian Asian & Black/African American Asian & White

American Indian/Alaskan Native Black/African American & White American Indian/Alaskan Native & White

Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black Other/Unknown

5

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: Male Female

Marital Status: Married Never Married

Separated Divorced Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? Yes No :

Program(s) Requested:

None AG SNAP TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? Yes No

If No, immigration status: _____

US Residency Date: ___/___/___

Alien Registration Number: _____

Is this person disabled or pregnant? Yes No

Is this person temporarily away from home? Yes No

Date Left ___/___/___ **Expected Return Date** ___/___/___

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Racial Heritage: White Black/African American Asian Asian & Black/African American Asian & White

American Indian/Alaskan Native Black/African American & White American Indian/Alaskan Native & White

Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native & Black Other/Unknown

Household Composition (continued)

- YES NO 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If YES, explain: _____
- YES NO 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: _____
- YES NO 5. Have any of your children received any immunizations since approval of your original application or since your most recent review? If YES, explain: _____
- YES NO 6. Have you or anyone for whom you are applying ever been disqualified from receiving TANF (AFDC) or SNAP benefits? If YES, explain: _____

B. RESOURCES

You do not have to complete this section if you are only renewing for TANF. Otherwise, answer for everyone for whom you are applying. Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

1. Do you or anyone who lives with you have any of the following resources or assets? .

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

— If you have **any of the above**, please provide the following information:

a.

_____ Owner Name (last, first, middle initial)		_____ Co-Owner Name (last, first, middle initial)	
_____ Name of Bank or Institution	_____ Account Type	_____ Account Number	_____ \$ Balance
_____ Address of Bank or Institution			

b.

_____ Owner Name (last, first, middle initial)		_____ Co-Owner Name (last, first, middle initial)	
_____ Name of Bank or Institution	_____ Account Type	_____ Account Number	_____ \$ Balance
_____ Address of Bank or Institution			

- YES NO 2. Has anyone sold, transferred or given away any resources in the last 3 months (for SNAP), in the last 3 years (for Auxiliary Grants)? If YES, explain: _____

Note: There are additional Resource questions in the Auxiliary Grant section if you are applying for that program.

C. INCOME

1. Do you or anyone who lives with you receive or expect to receive any of the following types of money from working? Include money from all jobs that you have now or expect to begin: full time, part time, seasonal, temporary, self-employment. Answer Yes or No below and provide the requested information:

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

_____ Name (last, first, middle initial)	_____ Employer Name, Address and Telephone Number	
_____ Number of Hours Per Week	_____ Rate of Pay	_____ Pay Schedule
_____ Date Job Started	_____ Next Pay Date (mm-dd-yyyy)	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other

INCOME (continued)

b.

Name (last, first, middle initial)	Employer Name, Address and Telephone Number		
Number of Hours Per Week	Rate of Pay	Pay Schedule	
Date Job Started	Next Pay Date (mm-dd-yyyy)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
		<input type="checkbox"/> Biweekly	<input type="checkbox"/> Twice a Month
		<input type="checkbox"/> Other	

YES NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked since you applied? If **YES**, give name and explain: _____

3. Do you or anyone who lives with you (including children) receive or expect to receive any of the following? Answer yes or no below and provide the requested information

- | | | | | | |
|--------------------------|---|--------------------------|--|--------------------------|---|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Social Security | <input type="checkbox"/> | <input type="checkbox"/> VA benefits | <input type="checkbox"/> | <input type="checkbox"/> Strike benefits |
| <input type="checkbox"/> | <input type="checkbox"/> Child support, alimony | <input type="checkbox"/> | <input type="checkbox"/> Unemployment benefits | <input type="checkbox"/> | <input type="checkbox"/> Prize winnings |
| <input type="checkbox"/> | <input type="checkbox"/> Cash gifts or contributions | <input type="checkbox"/> | <input type="checkbox"/> Room/board income | <input type="checkbox"/> | <input type="checkbox"/> All food, clothing, utilities, or rent |
| <input type="checkbox"/> | <input type="checkbox"/> Loans | <input type="checkbox"/> | <input type="checkbox"/> Black Lung benefits | <input type="checkbox"/> | <input type="checkbox"/> Other retirement |
| <input type="checkbox"/> | <input type="checkbox"/> SSI | <input type="checkbox"/> | <input type="checkbox"/> Worker compensation | <input type="checkbox"/> | <input type="checkbox"/> Interest, dividends |
| <input type="checkbox"/> | <input type="checkbox"/> Military Allotment | <input type="checkbox"/> | <input type="checkbox"/> Rental Income | <input type="checkbox"/> | <input type="checkbox"/> Insurance settlement |
| <input type="checkbox"/> | <input type="checkbox"/> Public Assistance (TANF, GR etc) | <input type="checkbox"/> | <input type="checkbox"/> Inheritance | <input type="checkbox"/> | <input type="checkbox"/> Any other type of money |
| <input type="checkbox"/> | <input type="checkbox"/> Training allowances (WIA, etc.) | <input type="checkbox"/> | <input type="checkbox"/> Railroad retirement | | |

a.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?
b.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?
c.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?

YES NO 4. Does anyone besides the people on your case pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? OR does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

YES NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

YES NO 6. Does anyone pay legally obligated child support to someone not in the household? If **YES**, give name of person paying, person supported, and amount: _____

D. FINANCIAL ASSISTANCE FOR CHILDREN

YES NO 1. Has the absent parent(s) begun supporting the children or changed the amount of support? If **YES**, explain: _____

YES NO 2. Has the legal parent(s) become disabled such that he or she is unable to work? If **YES**, explain: _____

YES NO 3. Do you have any new information that would help us locate the absent parent(s)? If **YES**, explain: _____

E. SNAP BENEFITS

1. List the name of the person who is the head of your household: _____
2. An authorized representative may apply for SNAP benefits on your behalf, receive and use your SNAP benefits on your behalf, or receive copies of your program notices. If you want to name an authorized representative, please give the information below about the representative and what you want the representative to do on your behalf.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	<input type="checkbox"/> Apply for SNAP benefits <input type="checkbox"/> Receive correspondence <input type="checkbox"/> Receive or use SNAP benefits

- YES NO 3. Is anyone living in your home NOT included in your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (✓) YES NO

- YES NO 4. Is anyone living in your home a roomer or boarder? If **YES**, list names: _____

- YES NO 5. Is anyone age 60 or older OR approved to receive Medicaid because of a disability OR receiving any type of disability payment? If **YES**, list all current medical expenses for these people.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

- YES NO 6. Do you have any of the following shelter expenses? If **YES**, list your current expenses. Check (✓) here if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes			
Insurance			
Electricity			
Gas/Oil/Kerosene			
Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Installation			

6a How do you heat your home? _____

- YES NO 6b Do you have air conditioning in your home?

- YES NO 6c Did you receive energy/fuel assistance during this past year while living in your current home?

- YES NO 6d Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?

If you are staying temporarily in someone else's home, when did you move there? _____

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, (AD-3027), found online at: 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.

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 (click the link for a listing of hotline numbers by State); found online at: 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.

Commonwealth of Virginia Voter Registration Agency Certification

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Please check only one)**

- I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
- No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, telephone (804) 864-8901.

Applicant Name

Signature

Date

for agency use only

Voter Registration form completed: Yes No
Voter Registration form given to applicant for later mailing (at applicant's request)

Agency Staff Signature

Date

BY MY SIGNATURE BELOW, I DECLARE, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PRESENTED HERE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I

understand:

- All of my responsibilities, including my responsibility to report required changes on time.
- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
- If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility, including reviews by Quality Assurance, my benefits may be denied until I cooperate.
- If my application is for SNAP, failure to report or verify of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself: Yes No

If NO, it was read back to me when complete: Yes No

Your Signature or Authorized Representative's Signature or Mark

Date

Witness to Mark or Interpreter

Date

Complete this section if this application was completed for the applicant by someone else.

Name of person completing application

Date

Relationship to applicant

Primary Telephone Number _____

Alternate Telephone Number _____

