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**GENERAL INFORMATION**

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Supplemental Nutrition Assistance Program (SNAP), (formerly food stamps)
- Temporary Assistance for Needy Families (TANF)
- General Relief
- Emergency Assistance
- Auxiliary Grants
- Refugee Cash and Medical Assistance
- Medical Assistance:
  - Medicaid
  - Plan First
  - FAMIS, FAMIS PLUS, FAMIS MOMS
  - State and Local Hospitalization

Individuals who have a disability or who have difficulty with English may receive extra help to make sure they get assistance or services they are eligible to receive.

**VERIFICATION AND USE OF INFORMATION**

The information that you give may be matched against Federal, State and local records, including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is complete, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social services agency at the same time, and make required program changes.

The Income and Eligibility Verification System (IEVS) may also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of Social Security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the U.S. Citizenship and Immigration Services (USCIS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

**SPECIAL INFORMATION FOR SNAP APPLICANTS**

You may apply for SNAP benefits by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

**You must also be interviewed in the office or by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your SNAP amount will be based on the date you actually turn in your application.**

**EXPEDITED SERVICE FOR SNAP BENEFITS**

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible and if your gross monthly income is less than \$150 and liquid resources are \$100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions  
 \$ \_\_\_\_\_

Total cash, money in checking/savings accounts, CDs  
 \$ \_\_\_\_\_

Total rent or mortgage for this month  
 \$ \_\_\_\_\_

Utility expenses for this month  
 \$ \_\_\_\_\_

Which utilities do you pay? (check all that apply)

Heat     Lights     Telephone     Electricity for Air Conditioning  
 Water     Sewer     Garbage     Other

Is anyone in your household a migrant or seasonal farm worker?    **YES ( )**  
**NO ( )**

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

# AGENCY USE ONLY

CASE NAME

CASE NUMBER

LOCALITY

WORKER

DATE

## EXPEDITED SERVICE DETERMINATION

Income less than \$150 and  
) **NO** ( ) **YES** ( )  
Resources \$100 or less

Income plus resources less than shelter bills **YES** ( ) **NO** ( )

For migrants or seasonal farm workers:

Resources \$100 or less, and in next 10 days  
\$25 or less is expected from new income:

**OR**

Resources \$100 or less, and no income  
is expected from a terminated source for  
the rest of this month or next month.

**NO** ( ) **YES** ( )

**EXPEDITE IF YES TO ANY OF THE ABOVE.**

## COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

## COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

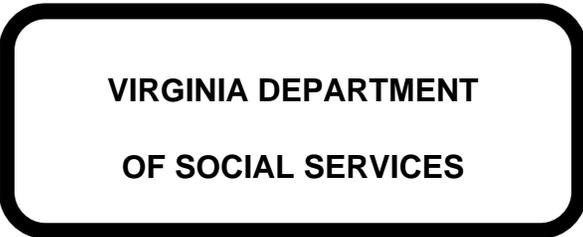
## FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

## YOUR SNAP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, the Virginia Department of Social Services is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, disability, political beliefs, or retaliation.

The Virginia Department of Social Services is an equal opportunity provider.



AGENCY USE ONLY				
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD	DATE RECEIVED
LOCALITY	DATE OF SERVICE REFERRAL		DATE OF INTERVIEW	<input type="checkbox"/> In office <input type="checkbox"/> Telephone

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		
LANGUAGE (Enter Code) _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C - Arabic F - French G - German J - Japanese O - Other		
YES ( ) NO ( ) A. Does anyone have an emergency medical need? If <b>YES</b> , give name and explain _____		
YES ( ) NO ( ) B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution? If <b>YES</b> , Date Applicant Entered _____ City/County and State Applicant lived before entering _____ If <b>outside Virginia</b> , was placement made by a government agency? <b>YES ( ) NO ( )</b>		
YES ( ) NO ( ) C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home? If <b>YES</b> , Spouse's Name _____ Spouse's Address _____		

1. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including SNAP Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	TYPE OF BENEFITS RECEIVED
WHEN	FROM WHAT COUNTY OR CITY OR STATE	

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, SNAP, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction \_\_\_\_\_

3. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If **YES**, explain \_\_\_\_\_

4. **YES ( ) NO ( )** Do you or anyone in your home have a felony conviction for drugs after August 22, 1996 for ( ) Use? ( ) Possession? ( ) Distribution of drugs? (check all that apply) If **YES**, who? \_\_\_\_\_ Did the court assign ( ) Periodic Testing? ( ) Drug Treatment? ( ) Other Action? **YES ( ) NO ( )** If **YES**, have you finished the plan or are you cooperating? **YES ( ) NO ( )**

5. **YES ( ) NO ( )** Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If **YES**, explain \_\_\_\_\_

# INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.
2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION**. Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.
3. Answer the questions in **SECTION B: RESOURCES** for everyone for whom you are applying unless you are applying for TANF, Plan First or FAMIS PLUS/FAMIS MOMS. In addition, if applying for **Medicaid** also provide resource information for the following persons:
  - Medicaid:** Spouse and children under age 21 who live with a person for whom you are applying.  
Parents who live with a child under age 21.  
Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.
4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF, Medicaid, Plan First or FAMIS PLUS/FAMIS** also provide income information for the following persons:
  - TANF:** Children age 18 or under, even if you are not applying for that child.  
Stepparent of the children for whom you are applying.
  - Medicaid/Plan First:** Spouse and children under age 21 who live with a person for whom you are applying.  
Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.
  - FAMIS PLUS/FAMIS** Parents and stepparents who live with a child under age 21.
5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.
 

<b>SNAP (Food Stamps)</b>	<b>Section D</b> , pages 8-9
<b>TANF/Medicaid</b>	<b>Section E</b> , page 10
<b>Refugee Cash and Medical Assistance</b>	<b>Section E</b> , page 10 <b>only</b> for children age 18 and under
<b>FAMIS PLUS/FAMIS</b>	<b>Section F</b> , page 11
<b>Medicaid/Auxiliary Grants/General Relief</b>	<b>Section G</b> , page 11
<b>General Relief</b> 18	<b>Section E</b> , page 10 <b>only</b> for children under age <b>Sections I &amp; J</b> , page 12
<b>State and Local Hospitalization</b>	<b>Section H</b> , page 12
<b>Emergency Assistance</b>	<b>Section J</b> , page 12
<b>Auxiliary Grants</b>	<b>Section K</b> , page 12
<b>Plan First</b>	<b>Section L</b> , page 12
6. Read **YOUR RESPONSIBILITIES** on page 13.
7. Read and complete **VOTER REGISTRATION** on page 13 of this application.
8. Read and complete the last page of this application. Be sure to sign and date the application.

# A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME <b>LIST EVERYONE LIVING IN YOUR HOME</b> , even if you are not applying for assistance for that person.  <b>LIST YOURSELF ON LINE #1.</b>  Check (✓) <b>YES</b> ( ) <b>NO</b> ( ) Do you expect any change in who lives in your home, either this month or next month? If YES, explain:  _____  _____  _____  LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)		2. TEMPORARILY AWAY FROM HOME  Is this person temporarily away from home?  Check (✓) <b>YES</b> or <b>NO</b>  If <b>YES</b> , give the date the person left and expected return date. If more than 60 days, give the reason for the absence.	3. RELATIONSHIP TO PERSON ON LINE #1  Give the relationship of each person to the person listed on Line #1.	4. TYPE OF ASSISTANCE REQUESTED (Check (✓) type of assistance requested for each person. If no assistance is requested, check <b>NONE</b> for that person. Note that an application for TANF will also be an application for SNAP. Check TANF - No SNAP if you do not want to apply for SNAP benefits.																
				SNAP (FOOD STAMPS)	TANF	TANF - NO SNAP	MEDICAL ASSISTANCE	PLAN FIRST	GENERAL RELIEF	EMERGENCY ASSISTANCE	AUXILIARY GRANTS	REFUGEE CASH ASSISTANCE	REFUGEE MEDICAL ASSISTANCE	NONE						
1	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
2	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
3	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
4	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
5	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
6	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
7	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		
8	ID# _____	YES ( ) NO ( ) Date Left _____ Expected Return Date _____ Reason _____																		

<p>Determine reason person is away. incarceration, etc.</p> <p>Determine if any parents or spouses live in the home. dependent</p> <p>Determine if persons under 18 are under parental control.</p> <p>Determine if anyone is a payee for anyone else.</p>	<p>Determine living arrangement, such as subsidized housing for elderly, hospital, if person is in ALF nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or relative is in the home.</p> <p>Determine living arrangement of the minor parent.</p>
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**USE THE FOLDOUT TO COMPLETE THIS SECTION**

<p><b>5. U.S. CITIZEN*</b></p> <p>Check (√) <b>YES or NO</b></p> <p>If YES, do not answer Question 6.</p> <p>You may leave this blank for anyone not in the assistance request</p>	<p><b>6. ANSWER ONLY IF AN ALIEN</b></p> <p>Give the <b>Alien Number</b> and <b>Date of Entry</b> for anyone for whom you are requesting assistance.</p> <p>You may leave this blank for anyone not in the assistance request.</p>	<p><b>7. PLACE OF BIRTH</b></p> <p>Give the <b>State</b> if born in the U.S. or the <b>Country</b> if born outside of the U.S.</p> <p><b>8. DATE OF BIRTH</b></p>	<p><b>9a. RACE</b> (not required)</p> <p>Select all that apply</p> <ol style="list-style-type: none"> <li>White</li> <li>Black/African American</li> <li>American Indian/Alaska Native</li> <li>Asian</li> <li>Native Hawaiian/Pacific Islander</li> </ol>	<p><b>9b. ETHNICITY</b> (not required)</p> <p>Give the <b>code</b> to show ethnicity.</p> <ol style="list-style-type: none"> <li>Hispanic or Latino</li> <li>Not Hispanic or Latino</li> </ol>	<p><b>10. SEX</b></p> <p>Give the <b>code</b> to show Sex.</p> <p>M - Male F - Female</p>	<p><b>11. SOCIAL SECURITY NUMBER</b></p> <p>Give the number for anyone for whom you are requesting assistance.</p>	<p><b>12. MARITAL STATUS</b></p> <p>Give the <b>code</b> to show Marital status.</p> <ol style="list-style-type: none"> <li>Married</li> <li>Never Married</li> <li>Divorced</li> <li>Widowed</li> <li>Separated</li> </ol>	<p><b>13. VETERAN/DEPENDENT OF A VETERAN</b></p> <p>Check (√) <b>YES or NO</b></p>
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number  Date of Entry	Place of Birth  Date of Birth						YES ( ) NO ( )

\*U.S. Citizens: You must prove you are a U.S. citizen for Medicaid purposes unless you receive SSI, SSDI, or you are a Medicare beneficiary. You must show documents such as a birth certificate to show that you are a citizen and you must prove your identity (often something with your picture on it) in order to receive Medicaid benefits. If you cannot provide documentation, let the worker know right away. Your Medicaid benefits could be canceled or denied if you do not tell us that you are trying to get these documents or that you need help. For children under age 16, a parent's or an authorized representative's signature on this application will serve as proof of identity, but you must still provide proof of citizenship for children under age 16.

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources. For Asylees, verify date asylum was granted. For Veterans, make referral to V.A.

**USE THE FOLDOUT TO COMPLETE THIS SECTION**

<b>14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH.</b>  Check (√) <b>YES</b> or <b>NO</b>  If <b>YES</b> , give the <b>Date of the Expense</b> .	<b>15. EDUCATION</b>  Give the <b>Last Grade Completed</b> in school.  Check (√) <b>YES</b> or <b>NO</b> Is the person a High School (HS) or GED graduate?  Check (√) <b>YES</b> or <b>NO</b> Is the person <b>Currently Enrolled</b> in school? If <b>YES</b> , give the <b>school name</b> and use one of the <b>codes</b> to show enrollment.  FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time  <div style="display: flex; justify-content: space-around;"> <span>SCHOOL NAME</span> <span>ENROLLMENT CODE</span> </div>		<b>16. DISABILITY/PREGNANT STATUS</b>  Give the <b>code</b> to show Disability/Pregnant Status  ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabled person PG - Pregnant	<b>17. ANSWER ONLY IF DISABLED</b>  A. Check (√) if the disability reduces or prevents the ability to work or to obtain work.  B. Check (√) if the disability reduces or prevents the ability to care for a child in the home.  C. Check (√) if the disability requires someone to be in the home to provide care.	<b>18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID AND FAMIS MOMS</b>  Give the <b>Conception</b> month and year and the <b>Expected Delivery Date</b> , and the number of <b>Unborn Children</b> .	
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn
YES ( ) NO ( )  Date	A. Last Grade Completed: _____ B. ( ) YES ( ) NO HS or GED Graduate C. ( ) YES ( ) NO Currently Enrolled				A. ( ) Ability to work is reduced B. ( ) Ability to care for child is reduced C. ( ) Someone is needed in the home	Conception  Delivery  # Unborn

For Medical Expenses, determine retroactive Medicaid entitlement.

## B. RESOURCES

**Do not complete this section if you are applying only for TANF, FAMIS PLUS, FAMIS, FAMIS MOMS, or Medicaid for parents of dependent children. If you are applying for Plan First, answer Question #9 only in this section. For all other programs, answer the resource questions for everyone for whom you are applying.** If applying for Medicaid for aged, blind, or disabled adults or medically needy children, also provide resource information for the spouse or parents. See Page 1a. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

**YES ( ) NO ( )** 1. Cash on hand and not in a bank? If **YES**, list owner(s) \_\_\_\_\_  
Amount \_\_\_\_\_

**YES ( ) NO ( )** 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (✓) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid \_\_\_\_\_. If the savings or investment account is for another purpose, explain \_\_\_\_\_

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT \$	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT \$	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT \$	DATE ACQUIRED

**YES ( ) NO ( )** 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, deeds of trust, mutual funds, IRAs, or annuities?

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT \$	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT \$	DATE ACQUIRED

**YES ( ) NO ( )** 4. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for SNAP benefits?  
In the last 2 years, if applying for **General Relief**? Any resources or income in the last 5 years if applying for **Medicaid**?

PROPERTY TRANSFERRED		VALUE AT TRANSFER \$	AMOUNT RECEIVED \$	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED	

**Answer the questions below this point (5-12B) only if this is an application for Medicaid, General Relief, Emergency Assistance, State and Local Hospitalization, Auxiliary Grants, or Refugee Medical Assistance.**

**YES ( ) NO ( )** 5. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE \$ AMOUNT OWED \$	DATE ACQUIRED
OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE \$ AMOUNT OWED \$	DATE ACQUIRED

**YES ( ) NO ( )** 6. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property necessary to your business or trade, including farming?	VALUE \$ AMOUNT OWED \$	DATE ACQUIRED
----------	------	---	----------------------------------	---------------

**YES ( ) NO ( ) 7. Real property, including life estates, land, buildings, or mobile homes? If YES, do you live there? Check (✓) YES ( ) NO ( )**

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	VALUE \$ AMOUNT OWED \$	DATE ACQUIRED
----------	--------------------------------	---	----------------------------------	---------------

**YES ( ) NO ( ) 8. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?**

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE \$ AMOUNT OWED \$	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE \$ AMOUNT OWED \$	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

**YES ( ) NO ( ) 9. Health insurance or long term care insurance?**

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT \$	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT \$	TYPE OF COVERAGE	PERSON(S) INSURED

**YES ( ) NO ( ) 10. Medicare?**

PERSON INSURED	CLAIM NUMBER	CHECK (✓) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (✓) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD

**YES ( ) NO ( ) 11. Life insurance policies?**

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE \$	CASH VALUE \$	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE \$	CASH VALUE \$	DATE ACQUIRED

**YES ( ) NO ( ) 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If YES, explain.**

**YES ( ) NO ( ) 12B. Does anyone expect a change in resources this month or next month? If YES, explain and give date change is expected.**

EXPLAIN
---------

**C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)**

Answer the income questions for everyone for whom you are applying. If applying for **TANF, Medicaid, Plan First** or **SLH**, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for **TANF** and **Medicaid/FAMIS PLUS/FAMIS** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES** or **NO** for each type. If **YES**, give the information requested.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <b>YES ( ) NO ( )</b> Wages/salary               | <b>YES ( ) NO ( )</b> Vacation Pay         | <b>YES ( ) NO ( )</b> Farming/fishing | <b>YES ( ) NO ( )</b> Other self-employment        |
| <b>YES ( ) NO ( )</b> Contract income            | <b>YES ( ) NO ( )</b> Earned sick pay      | <b>YES ( ) NO ( )</b> Domestic work   | <b>YES ( ) NO ( )</b> Any other money from working |
| <b>YES ( ) NO ( )</b> Commissions, bonuses, tips | <b>YES ( ) NO ( )</b> Babysitting/day care | <b>YES ( ) NO ( )</b> Odd jobs        |  |

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
				\$ PER			\$
				\$ PER			\$
				\$ PER			\$

2. Does anyone receive any other type of money? Check (√) **YES** OR **NO** for each type. If **YES**, give the information requested.

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

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				\$
				\$
				\$
				\$

**For Self Employment Income, determine expenses.**  
**For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.**  
**For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.**  
**For Rental Income, determine whether property is actively self-managed, expenses.**  
**For Earned Income, determine whether earnings include EITC advance payments.**  
**Inquire if SSI has been applied for.**

**For SNAP, investigate voluntary quit/work reduction.**  
**For TANF, determine the day care option.**  
**For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.**

**YES ( ) NO ( )** 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				\$ PER			

**YES ( ) NO ( )** 4. Does anyone besides the people for whom you are applying 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 or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			\$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			\$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

**YES ( ) NO ( )** 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	SCHOOL EXPENSES					
				TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR- TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (specify)
		\$	FROM TO	\$	\$	\$	\$	\$	\$
		\$	FROM TO	\$	\$	\$	\$	\$	\$

**YES ( ) NO ( )** 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: \_\_\_\_\_

**YES ( ) NO ( )** 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (✓) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		( ) Disabled		\$ PER
		( ) Disabled		\$ PER

**YES ( ) NO ( )** 8. Does anyone pay legally obligated child support to someone not in the household? If **YES**, person paying: \_\_\_\_\_

Person supported: \_\_\_\_\_ Amount paid and how often: \_\_\_\_\_

**YES ( ) NO ( )** 9. **ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES**, give amount and explain: \_\_\_\_\_

**D. SNAP (formerly FOOD STAMPS)**

1. List the name of the person who is the head of your household: \_\_\_\_\_.

NOTE: Discuss with your worker or refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES ( ) NO ( ) 2. Would you like to name an authorized representative who could apply for SNAP benefits for you, access your SNAP benefit account to buy food for you, or receive SNAP correspondence and notices for you? You may have only one representative who can access your benefits.

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)		CHECK (✓) EACH DUTY AUTHORIZED FOR THAT PERSON	
1		( ) Apply for SNAP benefits ( ) Receive SNAP benefits	( ) Receive correspondence
2		( ) Apply for SNAP benefits ( ) Receive SNAP benefits	( ) Receive correspondence

An authorized representative must have written permission to apply for SNAP benefits. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on 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 ( ) IF YES, list names: \_\_\_\_\_

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a 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 check?

If YES, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your SNAP benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		\$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		\$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		\$		( ) Lump sum ( ) Monthly average ( ) Expected payment

**YES ( ) NO ( )** 6. Does anyone have shelter expenses for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES**, answer question a, b, and c. Then, give the information requested in boxes.

- a. **YES ( ) NO ( )** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.
- b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **Yes**, leave those boxes blank.
- c. **YES ( ) NO ( )** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your SNAP application help you pay your telephone bill? Check (√) **YES ( )** or **NO ( )**

If **YES**, explain: \_\_\_\_\_

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
HOW OFTEN												
WHO PAYS BILL												

**YES ( ) NO ( )** 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your SNAP benefits determined using your actual utility expenses or a standard amount we use for these expenses. **TALK TO YOUR WORKER BEFORE ANSWERING. Actual Utility Expenses ( ) Utility Standard ( )**

If the **Utility Standard** is selected, does anyone living in your home but not included on your SNAP application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES**, explain: \_\_\_\_\_

**YES ( ) NO ( )** 8. 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 temporarily staying in someone else's home, give the date you moved in: \_\_\_\_\_

If **YES**, check (√) whether you would like your SNAP benefits determined using your actual shelter expenses or a standard amount we use for these expenses. **TALK TO YOUR WORKER BEFORE ANSWERING. Actual Shelter Expenses ( ) Homeless Shelter Allowance ( )**

**YES ( ) NO ( )** 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

**E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN**

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

<p><b>1. CHILD/PARENT INFORMATION</b></p> <p>List each child for whom you are applying. Then, list the names of both parents.</p> <p>YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED</p>	<p><b>2. PARENT'S STATUS</b> (Not needed for Medicaid)</p> <p>Check if either PARENT is:</p>				<p><b>3. IMMUNIZATION</b> (Not needed for Medicaid) (Answer <u>only</u> if applying for TANF and the child is not in school.)</p> <p>Has the child received <b>ALL</b> of the immunizations required according to the child's age?</p> <p>Check (✓) <b>YES</b> or <b>NO</b> or <b>UNKNOWN</b></p>
	UNEMPLOYED	DISABLED	DEAD	ABSENT	
CHILD'S NAME					YES ( )      NO ( )      UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( )      NO ( )      UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( )      NO ( )      UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( )      NO ( )      UNKNOWN ( )
MOTHER					
FATHER					

**F. FAMIS PLUS/FAMIS**

**YES ( ) NO ( )** 1. Did any of the children listed above have health insurance in the past 4 months? If **YES**, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: \_\_\_\_\_ Type of insurance: \_\_\_\_\_

Date ended \_\_\_\_\_

Reason insurance ended:

- ( ) The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
- ( ) The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
- ( ) Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
- ( ) Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
- ( ) Stopped/dropped by someone other than parent or stepparent.
- ( ) Stopped/dropped Cobra policy
- ( ) Other \_\_\_\_\_

**YES ( ) NO ( )** 2. Is any member of the family, including a stepparent who lives in the home, employed by a state or local government agency? If **YES**, list name of family member(s) and agency name: \_\_\_\_\_

**YES ( ) NO ( )** 3. Does the employer of any member of the family offer health insurance for family members? If **YES**, list the names of the children listed on this application who can get insurance through the employer? \_\_\_\_\_

**G. AGED, BLIND OR DISABLED INDIVIDUALS**

**YES ( ) NO ( )** 1. Have you ever applied for Supplemental Security Income (SSI) or Social Security as a disabled person? If **YES**, date applied: \_\_\_\_\_  
Check one: ( ) No Decision Yet ( ) Application Approved ( ) Application Denied

**YES ( ) NO ( )** 2. If your application was denied, did you file an appeal of the denial? If **YES**, explain the action taken by the Social Security Administration (SSA) on the appeal request? \_\_\_\_\_

**YES ( ) NO ( )** 3. Has it been less than 12 months since your most recent application for Social Security or SSI disability benefits was denied? If **YES**, list the medical conditions that you asked SSA to evaluate. \_\_\_\_\_

**YES ( ) NO ( )** 4. Has your condition changed or worsened since your most recent application for Social Security or SSI disability benefits was denied. If **YES**, explain how your condition has changed or worsened. \_\_\_\_\_

**YES ( ) NO ( )** 5. Do you have a new condition that has occurred since your most recent application for Social Security or SSI disability benefits was denied? If **YES**, explain the new condition. \_\_\_\_\_

**YES ( ) NO ( )** 6. Did you receive an Auxiliary Grants check that has stopped? If **YES**, explain when and why the payments stopped. \_\_\_\_\_  
\_\_\_\_\_

**YES ( ) NO ( )** 7. Did you receive a SSI check that has stopped? If **YES**, explain when and why the payments stopped. \_\_\_\_\_  
\_\_\_\_\_

**H. STATE AND LOCAL HOSPITALIZATION**

**YES ( ) NO ( )** Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If **YES**, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: _____ DATE DISCHARGED: _____
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If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES ( ) NO ( )
NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED		NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

**I. GENERAL RELIEF**

**YES ( ) NO ( )** Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pay?

**J. GENERAL RELIEF/EMERGENCY ASSISTANCE**

**YES ( ) NO ( )** Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY
------------------------------------

**K. AUXILIARY GRANTS**

**YES ( ) NO ( )** 1. Do you own any household goods or personal effects which are worth more than \$500, such as silver, fine china, furs, artwork, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS
--------------------------------

**YES ( ) NO ( )** 2. Do you owe or did you pay in the month of application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID
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**L. PLAN FIRST**

**YES ( ) NO ( )** Has the person(s) applying for Plan First coverage had a procedure that now prevents pregnancies (tubes tied, hysterectomy)? For men, this includes a vasectomy. If yes, please list the person's name: \_\_\_\_\_.

## YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

### CHANGES

You must report the following changes for the Medicaid Program within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs.

- 1) Change of address and any changes in shelter costs due to the move
- 2) Change in the persons in the household – person left, person born, etc.
- 3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
- 4) Change in work hours from part-time to full-time or full-time to part-time
- 5) Change in rate of pay per hour/day, etc.
- 6) Change in the amount of monthly income received other than from a job, including the loss of SSI benefits
- 7) Change in resources, including transferring assets/property
- 8) Change in motor vehicles owned
- 9) Change in marital status
- 10) Person in home is no longer disabled
- 11) Change in dependent care expenses
- 12) Change in insurance
- 13) Termination of a pregnancy
- 14) Other changes that may affect eligibility

You must report the following changes for the SNAP and TANF Programs within 10 days, but no later than the 10<sup>th</sup> day of the month after the change occurs.

- 1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
- 2) Change in address.
- 3) An eligible child has left the home.
- 4) Changes needed for VIEW (TANF work program).
- 5) Change in work hours for some SNAP recipients.

### PENALTIES FOR SNAP VIOLATIONS

**You must not give false information or hide information to get SNAP benefits. You must not trade or sell EBT cards. You must not use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.**

**If you intentionally break any of these rules you could be barred from getting SNAP benefits for 12 months (1<sup>st</sup> violation), 24 months (2<sup>nd</sup> violation), or permanently (3<sup>rd</sup> violation); subject to \$250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.**

**If you intentionally give false information or hide information about identity or residence to get SNAP benefits in more than one locality at the same time, you could be barred for 10 years.**

**If you are convicted in court of trading or selling SNAP benefits of \$500.00 or more, you could be barred permanently.**

**If you are convicted in court of trading SNAP benefits for a controlled substance, you could be barred for 24 months for the 1<sup>st</sup> violation, permanently for the 2<sup>nd</sup> violation.**

**If you are convicted in court of trading SNAP benefits for firearms, ammunition, or explosives, you could be barred permanently for the first violation.**

### INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

### PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1<sup>st</sup> violation), 12 months (2<sup>nd</sup> violation), or permanently (3<sup>rd</sup> violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, SNAP benefits or SSI in two or more states is ineligible for TANF for 10 years.

**Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.**

### PENALTIES FOR MEDICAID FRAUD/ABUSE

You must not deliberately withhold or hide information or give false information to get Medicaid, FAMIS Plus or Plan First benefits. Medicaid fraud also occurs when a provider bills for services that were not delivered to a Medicaid recipient, or when a recipient shares the Medicaid number with another person to get medical services.

If you are convicted of Medicaid fraud in a criminal court, you must repay the program for all losses (paid claims or managed care premiums) and cannot get Medicaid for one year after conviction. In addition, the sentence could include a fine up to \$25,000 and up to 20 years in prison. You may also have to repay any claims and managed care premiums paid when you were not eligible for Medicaid due to acts that are not considered criminal. Fraud and abuse should be reported to your local social services office or to the Department of Medical Assistance Services Recipient Audit Unit at (804) 785-0156.

## VOTER REGISTRATION

**If you are applying for TANF, SNAP, Medicaid or Plan First, check one of the following:**

**If you are not registered to vote where you live now, would you like to register to vote here today?**

- Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- I do not want to apply to register to vote today.

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. 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 to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 864-8901.

**BY MY SIGNATURE BELOW, I DECLARE:**

- I understand all the information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Assurance, my benefits may be denied until I cooperate.
- I understand that if my application is for SNAP benefits, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for these expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies to assist with application, enrollment, administration, and billing for services provided to my child in school. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/FAMIS PLUS/Plan First/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I believe I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.
- I understand that I must report ownership of all annuities my spouse or I have. I also understand that my spouse and I may have to name the Commonwealth of Virginia as the beneficiary on any annuities we may have in order for Medicaid to pay long-term care costs.
- If I am applying for Medicaid, I understand that I must cooperate in establishing paternity and obtaining medical support for my children. I understand that failure to cooperate may cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames (10 days); (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/FAMIS PLUS/Plan First. For FAMIS/ FAMIS MOMS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- I understand that my signature on this application certifies, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status (unless applying for emergency services only). I understand the information provided on this application can be used to establish identity for children under age 16 for medical assistance purposes.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply as long as my medical assistance case is open or to investigations regarding possible fraud.

I received the Benefit Programs Booklet YES ( ) NO ( )

**MEDICAID APPLICANTS:** I received the Medicaid Handbook YES ( ) NO ( )

**TANF APPLICANTS:**

The diversionary assistance program was explained to me. YES ( ) NO ( )

The family cap provision was explained to me. YES ( ) NO ( )

I filled in this application myself. YES ( ) NO ( )

If NO, it was read back to me when completed. YES ( ) NO ( )

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

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

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		REALATIONSHIP TO APPLICANT

APPLICATION FOR BENEFITS

FORM NUMBER - 032-03-0824

PURPOSE OF FORM - To record a household's request for assistance and to provide information about the current situation needed to determine eligibility.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The application is to be completed by or on behalf of the applying household. The completed application may be mailed to the agency or completed at the agency prior to or during an interview. The completed application is to be filed in the eligibility case record. The application must be retained for a minimum of three years.

The application may be used to apply for benefits of other programs if assistance is requested within three months of the original filing date. The date of the application in this instance is the date of the secondary request.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.



**Commonwealth of Virginia  
Department of Social Services  
ELIGIBILITY REVIEW – PART A**

CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED
CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED

This is a review to determine if you continue to be eligible for benefits. Please give correct and complete information on both Part A (this form) and Part B (Separate Form).  
**IF YOU ARE REPORTING A NEW HOUSEHOLD MEMBER, COMPLETE THE INFORMATION ON THE BACK OF THIS PAGE FOR THE NEW MEMBER.**

**A. HOUSEHOLD INFORMATION**

1. Give your name, address and phone number.

NAME	PHONE NUMBER (HOME)	(WORK)
ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)	DIRECTIONS TO HOME	
MAILING ADDRESS (IF DIFFERENT)		

2. List yourself on the first line. Then, list everyone else living in your home, **even if you are not applying for that person**. Include people temporarily away and check the "AWAY" block for them. Give the information requested for each person.

NAME (IF AWAY, CHECK AWAY BLOCK)		PROGRAM(S) REQUESTED					RELATIONSHIP TO YOU	You may leave this blank for anyone not in the assistance request. SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	CHECK (✓) IF IN SCHOOL?		IF IN SCHOOL NAME OF SCHOOL
LAST, FIRST, MIDDLE INITIAL (MAIDEN)	AWAY	SNAP Benefits (food stamps)	TANF	MEDICAID	IF OTHER, SPECIFY	NONE					YES	NO	

If you answer "YES" to any of the following questions, please explain below.

- YES ( ) NO ( ) 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
- YES ( ) NO ( ) 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs?
- YES ( ) NO ( ) 5. Is anyone now blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person?
- YES ( ) NO ( ) 6. Have any of your children received any immunizations since approval of your original application or since your most recent review?
- YES ( ) NO ( ) 7. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), SNAP benefits, or Medicaid in two or more areas at the same time?

If YES, explain: \_\_\_\_\_

8. **NEW HOUSEHOLD MEMBER INFORMATION** – Give the following information for any new household member you are reporting for the first time. For **TANF and SNAP**, also give this information for any new member you have verbally reported since your original application or since your most recent eligibility review.

NAME LAST NAME, FIRST, MI (MAIDEN)	PROGRAM(S) REQUESTED	RELATION- SHIP TO YOU	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	**		SEX	MARITAL STATUS	CITIZEN- SHIP*	ALIEN REGISTRATION NUMBER*	LAST GRADE	CHECK (√) IF IN SCHOOL		CHECK (√) IF A VETERAN		
					RACE	HISPANIC YES   NO						YES	NO	YES	NO	

\* -You may leave this blank for anyone not in the assistance request.

\*\* - Not required.

YES ( ) NO ( ) 9. Is anyone listed above blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person? If YES, explain: \_\_\_\_\_

YES ( ) NO ( ) 10. Is anyone listed above in violation of parole or probation, or fleeing capture to avoid prosecution or punishment of a felony? If Yes, explain: \_\_\_\_\_

YES ( ) NO ( ) 11. Has anyone listed above been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: \_\_\_\_\_

YES ( ) NO ( ) 12. Has anyone listed above ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), SNAP (Food Stamps), or Medicaid in two or more areas at the same time? If YES, give date and place of conviction: \_\_\_\_\_

YES ( ) NO ( ) 13. **(DOES NOT APPLY TO SNAP OR TANF)**: Does anyone listed above have any unpaid medical expenses during the last 3 months?

YES ( ) NO ( ) 14. **(DOES NOT APPLY TO SNAP)**: If applying for children, list the name(s) and address(es) of any absent parent(s): \_\_\_\_\_

YES ( ) NO ( ) 15. **(DOES NOT APPLY TO SNAP OR TANF)**: If the parents are separated and living apart, does the absent parent(s) provide financial support, physical care, or guidance? If YES, explain: \_\_\_\_\_

**ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT:** As long as you are covered by Medicaid or State/Local Hospitalization (SLH), you are required to assign all of your rights to medical support to the Department of Medical Assistance Services (DMAS) and give to DMAS any payment for medical services you receive from another insurer. You are also required to assign these same rights for everyone else for whom you have the legal right to do so. Failure to assign your rights will make you ineligible for Medicaid or SLH. Failure to assign the rights of anyone else will not make that person ineligible for Medicaid. If you are unwilling to assign the rights of a new household member(s), initial the block below and list the name(s) of the person(s) whose rights you do not wish to assign. Otherwise, your signature indicates you agree to assign the rights of the new household member(s).

I refuse to assign the rights of \_\_\_\_\_

\_\_\_\_\_  
Your Signature or Authorized Representative's Signature or Mark                      Date                      Witness for Mark                      Date

By my signature below, I declare that the household member(s) for whom I am requesting Food Stamps, TANF, Medicaid (unless I am applying for emergency medical services only), is/are either a U.S. citizen(s) or alien(s) in lawful immigration status, and I declare under penalty of law that all information on this form is correct and complete to the best of my knowledge and belief. The Virginia Department of Social Service is an equal opportunity provider. I understand that if there is a SNAP claim against my household, the information on this application, including all SSNs, may be referred to federal and state agencies as well as private claims collection agencies for claims collection action.

\_\_\_\_\_  
Your Signature or Authorized Representative's Signature or Mark                      Date                      Witness for Mark                      Date

**Commonwealth of Virginia  
Department of Social Services  
ELIGIBILITY REVIEW – PART B**

CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED
CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED

**B. RESOURCES** Answer for everyone for whom you are applying. Include any resources anyone owns, is buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resources owned by that person. **Talk to your eligibility worker if you need help answering these questions, including help with the percentage owned. Answer only #1 and # 8 for SNAP.**

- YES  NO 1. Does anyone have cash, money in checking/savings/credit union/Christmas Club/money market/individual development account/or any other account, CD's, patient funds, special welfare accounts, stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, deeds of trust, or burial plots/arrangements/trust funds? Has a savings or investment account been set up to pay for school, to make a down payment on a house or to start a business, or for another purpose? Check (✓):  YES  NO  
If the savings or other investment accounts is for **school expenses**, give name of person whose expenses will be paid: \_\_\_\_\_  
If the savings or investment account is for another purpose, explain \_\_\_\_\_

OWNER(S)	TYPE (ACCOUNT #)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE \$	DATE ACQUIRED
OWNER(S)	TYPE (ACCOUNT #)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE \$	DATE ACQUIRED
OWNER(S)	TYPE (ACCOUNT #)	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT OR VALUE \$	DATE ACQUIRED

- YES  NO 2. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property used in your business or trade, including farming?	VALUE \$ AMOUNT \$ OWED	DATE ACQUIRED
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- YES  NO 3. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes? If YES, do you live there? Check (✓):  YES  NO

OWNER(S)	TYPE	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income-producing YES ( ) NO ( ) Currently for sale	VALUE \$ AMOUNT \$ OWED	DATE ACQUIRED
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- YES  NO 4. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

OWNER(S)	TYPE OF VEHICLE: YEAR-MAKE-MODEL	CURRENTLY LICENSED <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE #	VALUE \$ AMOUNT \$ OWED	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
	VEHICLE ID#					
OWNER(S)	TYPE OF VEHICLE: YEAR-MAKE-MODEL	CURRENTLY LICENSED <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE #	VALUE \$ AMOUNT \$ OWED	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
	VEHICLE ID#					

- YES  NO 5. Does anyone have health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE	ID NUMBER	TYPE OF COVERAGE	PERSON(S) INSURED
		END DATE	PREMIUM AMOUNT \$		

YES  NO 6. Does anyone have Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (✓) <input type="checkbox"/> PART A <input type="checkbox"/> PART B	BEGIN DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (✓) <input type="checkbox"/> PART A <input type="checkbox"/> PART B	BEGIN DATE	PREMIUM	PAYMENT METHOD
			END DATE	\$	
			END DATE	\$	

YES  NO 7. Does anyone have life insurance, retirement insurance, or other related types of insurance policies?

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE	CASH VALUE	DATE ACQUIRED
					\$	\$	

YES  NO 8. Has anyone sold, transferred or given away any resources in the last 3 months (for **SNAP**), in the last 2 years (for **TANF** or **General Relief**), or resources **or income** in the last five years (for **Medicaid**)? If **YES**, explain: \_\_\_\_\_

**C. INCOME** Answer for everyone for whom you are applying. For **TANF** and **Medicaid** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide information for the parent of the minor parent.

YES  NO 1. Does anyone receive any money from any source? Include money received from self-employment, pensions, income-producing property, support or contributions. If **YES**, give the information requested. If the money is received from working, give employment information.

PERSON RECEIVING MONEY	TYPE OF MONEY	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMT. BEFORE DEDUCTIONS	EMPLOYER'S NAME, ADDRESS, PHONE NUMBER	EMPLOYMENT BEGIN DATE	HRS/MONTH WORKED
				\$			
				\$			
				\$			
				\$			

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: \_\_\_\_\_

YES  NO 3. 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 4. Has anyone applied for or received student financial aid or work-study for a current school term at any college, university, school or training program beyond the high school level, or any school or training program for persons with a physical or mental disability?

NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION FEES	BOOKS SUPPLIED	TRANSPOR-TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (Specify)
		\$	FROM TO	\$	\$	\$	\$	\$	

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. SNAP Benefits**

1. List the name of the person who is the head of your household.

HEAD OF HOUSEHOLD
-------------------

NOTE: Talk to your worker for additional information.

YES  NO 2. Would you like to name an authorized representatives who could apply for SNAP benefits for you, receive or use your SNAP benefits in grocery stores for you, or receive SNAP correspondence and notices for you?

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	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. If anyone age 60 or older OR approved to receive Medicaid because of a disability OR receiving any type of disability check? If **YES**, list all current medical expenses for these people. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		\$		<input type="checkbox"/> LUMP SUM <input type="checkbox"/> MONTHLY AVERAGE <input type="checkbox"/> EXPECTED PAYMENT
		\$		<input type="checkbox"/> LUMP SUM <input type="checkbox"/> MONTHLY AVERAGE <input type="checkbox"/> EXPECTED PAYMENT

YES  NO 6. Does anyone have any of the following shelter expenses? Check (✓) here  if these expenses are for a house not lived in.

EXPENSES	RENT OR MORTGAGE	TAXES	INSURANCE	ELECTRICITY	GAS	KEROSENE	COAL	OIL	WOOD	WATER/SEWER	GARBAGE	TELEPHONE	INSTALLATION
AMOUNT BILLED	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
HOW OFTEN													
WHO PAYS BILL													

a. Households which have a heating or cooling expense OR received fuel assistance during this past year can use actual utility expenses or a standard amount for these expenses called the "Utility Standard." Check (✓) which amount you would like to use.  Actual utility expenses  Utility standard If Utility Standard, does anyone living in your home but not in your case help you pay heating/cooling? Check (✓)  YES  NO If **YES**, explain \_\_\_\_\_

b. Households which do not have a permanent residence can use actual shelter expenses or a standard amount for these expenses called the "Shelter Standard." Check (✓) which amount you would like to use.  Actual shelter expenses  Shelter standard if temporarily staying in someone else's home, give date moved in \_\_\_\_\_.

**E. FINANCIAL AND MEDICAL ASSISTANCE FOR CHILDREN**

- YES  NO 1. Has the absent parent(s) changed the amount of financial support, physical care, or guidance regularly provided to the children?  
If **YES**, explain: \_\_\_\_\_
- YES  NO 2. Has the legal parent 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; \_\_\_\_\_

**F. AUXILIARY GRANTS**

- YES  NO 1. Do you own any household goods or personal effects which are worth more than \$500? If **YES**, and you did not report these items in the Resource Section, list the items and their value her: \_\_\_\_\_

**G. CHANGES EXPECTED THIS MONTH OR NEXT:** \_\_\_\_\_

**VOTER REGISTRATION**

If you are applying for TANF, SNAP or Medicaid, check one of the following:

If you are not registered to vote where you live now, would you like to register to vote here today?

- Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- I do not want to apply to register to vote today.

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. 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 to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 864-8901.

Agency Use Only: Face-to-face interview not required. A voter registration form was mailed. Date form mailed \_\_\_\_\_

**BY MY SIGNATURE BELOW, I DECLARE UNDER PENALTY OF PERJURY THAT ALL OF THE FOLLOWING IS TRUE:**

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.
- All information on this form is correct and complete to the best of my knowledge and belief.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility AND the release of any medical or psychological information obtained from any source to the state or local agency that may review this application for financial or medical assistance. 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	SPOUSE'S SIGNATURE OR MARK (NOT NEEDED FOR SNAP)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

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

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME)	(WORK)	RELATIONSHIP TO APPLICANT

ELIGIBILITY REVIEW FORMS

FORM NUMBER - 032-03-729A  
032-03-729B

PURPOSE OF FORM - (1) To record a household's situation in order to review eligibility; and (2) to gather information about a new household member who is to be added at the time of the review. Though not required for SNAP benefits, the review forms may be used to gather information about a new household member who is to be added during the certification period.

USE OF FORM - These forms are limited to reviews. They may not be used in lieu of an application to either apply for benefits or to protect the date of application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - These forms are completed at the time of the eligibility review or when new household members are added. Completed forms are to be filed in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORMS - For reviewing eligibility, the front of Part A and all of Part B must be completed. If new household members are to be added at the time of the review, the back of Part A must also be completed.

Requirements for adding new household members between reviews vary by program. For SNAP purposes, a new member may be added based on information provided verbally by a responsible household member. The household does not have to annotate the application, sign and date the application again, or complete the back of Part A. At a minimum, the household must provide a verbal statement of the information on the back of Part A about the new member and note income, resource, or expense changes. The back of Part A and Part B, in its entirety, must be completed in writing at the end of the next review.



**EVALUATION OF ELIGIBILITY**

**1. GENERAL INFORMATION**

	PROGRAM	APPLICATION DATE	INTERVIEW DATE
CASE NAME	CASE NUMBER		
SECONDARY CASE NAME	SECONDARY CASE NUMBER		
IDENTITY (NAME)	VERIFICATION		
HEAD OF HOUSEHOLD ADULT PARENT/PARENTAL CONTROL? <input type="checkbox"/> Y <input type="checkbox"/> N DESIGNATED BY HH <input type="checkbox"/> AGENCY		FACE-TO-FACE INTERVIEW <input type="checkbox"/> Y <input type="checkbox"/> N IF NO, REASON:  Telephone Interview? <input type="checkbox"/> Y <input type="checkbox"/> N	
ADDRESS	SECONDARY ADDRESS TYPE	INSTITUTIONAL STATUS Date NF CBC ACR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
VERIFICATION/REMARKS	VIRGINIA <input type="checkbox"/> Y <input type="checkbox"/> N RESIDENT?	ACR/AFC RATE:	DMAS-96 <input type="checkbox"/> Y <input type="checkbox"/> N SAR <input type="checkbox"/> Y <input type="checkbox"/> N

**2. MEMBER INFORMATION**

NAME OR MBR#	HH/UNIT MEMBERSHIP CHECK (✓) IF INCLUDED						PERMANENT VERIFICATIONS CHECK (✓) IF REQ. MET				SNAPET/ESP/VIEW REGISTRATION OR REFERRAL	ATTENDING SCHOOL?	DEPRIVATION (MED - ONLY EFF 7/1/99)	IMMUNIZATION REQUIREMENT MET?
	SNAP	TANF	MED	AG	MEDICAID/AG CATEGORY	OTHR (LIST)	SSN	DOB	CIT	REL	IF YES, DATE IF NO, REASON	DOCUMENT TRUANCY	GIVE REASON	GIVE VERIFICATION
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			
	<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"/> Y <input type="checkbox"/> N			

NAME	PROGRAM	REASON FOR EXCLUSION, DISQUALIFICATION OR INELIGIBILITY	TIME PERIOD

ASSIGNMENT OF RIGHTS <input type="checkbox"/> Y <input type="checkbox"/> N	NOTICE OF COOPERATION AND GOOD CAUSE SIGNED? <input type="checkbox"/> Y <input type="checkbox"/> N IDENTITY EXCEPTION CLAIMED: <input type="checkbox"/> Y <input type="checkbox"/> N	GOOD CAUSE CLAIMED? <input type="checkbox"/> Y <input type="checkbox"/> N	LIVING WITH SPECIFIED RELATIVE/GUARDIAN <input type="checkbox"/> Y <input type="checkbox"/> N
DEPRIVATION, TRUANCY, PREGNANCY, CONCEPTION/DELIVERY DATE, FOSTER CARE/ADOPTION STATUS, DISABILITY/BLINDNESS OR OTHER DOCUMENTATION			

### 3. MEDICAID

RETROACTIVE DETERMINATION NECESSARY? <input type="checkbox"/> Y <input type="checkbox"/> N RETROACTIVE PERIOD	POTENTIALLY PROTECTED MEMBERS PROTECTED MEMBERS (INCLUDED STATUS)	COMMUNITY SPOUSE? <input type="checkbox"/> Y <input type="checkbox"/> N
--	--	--

### 4. DOCUMENTATION OF UNIT OR HH MEMBERSHIP, MEDICAID PROTECTED STATUS, VOLUNTARY QUIT, WORK REDUCTION, WORK REQUIREMENT.

### 5. RESOURCES (EVALUATE SAVINGS OR INVESTMENT ACCOUNT FOR ANY PURPOSE LEADING TO SELF-SUFFICIENCY)

CASH  Y  N      ACCOUNTS  Y  N      STOCKS/BONDS  Y  N      PENSION PLANS  Y  N      TRUST FUNDS  Y  N      RETIREMENT  Y  N      PROGRAM(S)

MBR	TYPE	AMOUNT	INSTITUTION, ACCT NAME, ACCT#	VERIFICATION CALCULATIONS, WITHDRAWLS			
COUNTABLE							

PROMISSORY NOTES/DEEDS OF TRUST  Y  N      BURIAL  Y  N      PERSONAL PROPERTY  Y  N      REAL PROPERTY  Y  N      PROGRAM(S)

MBR	TYPE	AMOUNT	ADDITIONAL EXPLANATION, VERIFICATION, CALCULATIONS			
COUNTABLE						

VEHICLES  Y  N      DMV  MATCH  NO MATCH      DATE      PROGRAM(S)

MBR	YEAR, MAKE, MODEL	USE	FMV	FS LIMIT	EXCESS	LIEN	EQUITY	VERIFICATION, CALCULATIONS			
COUNTABLE											

HEALTH INSURANCE  Y  N      MEDICAID: HIPP APPLICATION, MEDICAL QUESTIONNAIRE COMPLETED  Y  N

MBR	TYPE	COMPANY	POLICY ID#	VERIFICATION	PREMIUM

LIFE INSURANCE  Y  N (NOT APPLICABLE FOR SNAP)

PROGRAM(S)

MBR	OWNER	TYPE	FACE \$	CASH \$	COMPANY ACCT#	VERIFICATION			
01									
							COUNTABLE		

**6. TRANSFER OF RESOURCES**  Y  N (MEDICAID: ALSO EVALUATE TRANSFER OF INCOME)

MBR	TYPE, DATE	VALUE	AMOUNT \$	VERIFICATION, CALCULATION OF PERIOD OF INELIGIBILITY	
					SNAP TANF MED _____

**7. EARNED INCOME**  Y  N

PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	HRS/WK	VERIFICATION			
							COUNTABLE		

**8. UNEARNED INCOME**  Y  N

PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	VERIFICATION			
							COUNTABLE	

VEC  Match  No Match Date SOLQ-I  SVES  Match  No Match Date APECS  Match  No Match Date

CALCULATIONS (DOCUMENT DISREGARDS, INCOME SCREENINGS, SELF EMPLOYMENT EXPENSES, SCHOOL EXPENSES, CHILD SUPPORT)

APPLICATION FOR OTHER BENEFITS: () SSA () SSI () UCB () VA () OTHER

TOTAL COUNTABLE RESOURCES			
SNAP	TANF	MEDICAID	
\$	\$	\$	\$

TOTAL COUNTABLE INCOME			
SNAP	TANF	MEDICAID	
\$	\$	\$	\$

**9. EXPENSES**

SHELTER EXPENSES  Y  N

TYPE OF EXPENSE	MO. AMT.	VERIFICATION
RENT/MORTGAGE		
ELECTRICITY		
GAS/KEROSENE/COAL OIL/WOOD		
WATER/SEWER		
GARBAGE		
INSTALLATION		
TAX/INSURANCE		

DAY CARE EXPENSES  Y  N CHILD SUPPORT DEDCUTION  Y  N

MBR	MO. AMT.	DESCRIPTION VERIFICATION

MEDICAL EXPENSES  Y  N

MBR	MO. AMT.	DESCRIPTION, VERIFICATION, METHOD OF DEDUCTION

UTILITY STANDARD  Y  N  1-3  4+ PHONE STANDARD  Y  N HOMELESS STANDARD  Y  N

REASON FOR ENTITLEMENT TO STANDARD:

**10. GENERAL RELIEF (MAINTENANCE)**

Period of Unemployment \_\_\_\_\_  
 Applied for SSI  Decision appealed   
 Release of SSI check signed \_\_\_\_\_  
 Modified Standard  Full Standard   
 Reason for Standard \_\_\_\_\_

**11. EMERGENCY ASSISTANCE** ( GR ( TANF-EA

Date and Reason for Emergency: \_\_\_\_\_  
 Assistance Previously Received  Y  N  
 Date and Amount Received: \_\_\_\_\_

**12. STATE AND LOCAL HOSPITALIZATION**

MBR	Services Dates	Provider Name	Applied within 30 days? <input type="checkbox"/> Y <input type="checkbox"/> N

**13. DIVERSIONARY ASSISTANCE PROGRAM**

Loss/Delay of Income  Y  N TANF Requirement Met?  Y  N EVALUATION:

Emergency Need \$ \_\_\_\_\_ Type \_\_\_\_\_

TANF \$ \_\_\_\_\_ (Max 4 months) Payment \$ \_\_\_\_\_ Date Issued \_\_\_\_\_

Vendor Payment Issued to: \_\_\_\_\_

TANF Period of Ineligibility: \_\_\_\_\_

Diversiory Assistance Ineligibility (60 mos.) Ends: \_\_\_\_\_

Acceptance Signed:  Y  N Date: \_\_\_\_\_

**14. SPEND-DOWN CALCULATION**

COUNTABLE INCOME \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ SPEND-DOWN PERIOD: FROM \_\_\_\_\_ TO \_\_\_\_\_

MINUS INCOME LEVEL \_\_\_\_\_ Person(s) on Spend-down: \_\_\_\_\_

EXCESS INCOME \_\_\_\_\_ Person(s) on Spend-down: \_\_\_\_\_

**15. DISPOSITION**

BENEFIT PROGRAMS  
DATE GIVEN: BOOKLET

SNAP  
HOTLINE

MEDICAID  
HANDBOOK

PROGRAM	DISPOSITION (Denial Resources)	EFFECTIVE DATE/ CERT/COVERED PERIOD	HH/AU SIZE	MONTHLY BENEFITS	PRORATED BENEFITS	SIGNATURE AND DATE (WORKER/SUPERVISOR)

EVALUATION OF ELIGIBILITY

FORM NUMBER - 032-03-0823

PURPOSE OF FORM - To document verification of elements used to determine eligibility and to document eligibility decisions.

USE OF FORM – May be completed by the eligibility worker at application and review.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form is to be kept in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the elements required for the program. If an element section is not appropriate for the program, mark Not Applicable (NA). If an entire section does not apply, leave the section blank.

Complete the disposition section to summarize the eligibility decision. The form must be signed by the eligibility worker and should be signed by the supervisor, if a review of the action is completed.



**PARTIAL REVIEWS AND CHANGES**

CASE NAME	CASE NUMBER	FIPS
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PROGRAM	ACTION DATE	EFFECTIVE DATE	REASON FOR REVIEW, METHODS AND DATES OF VERIFICATION	SIGNATURE AND DATE (Worker/Supervisor)

PROGRAM	ACTION DATE	EFFECTIVE DATE	REASON FOR REVIEW, METHODS AND DATES OF VERIFICATION	SIGNATURE AND DATE (Worker/Supervisor)

PARTIAL REVIEWS AND CHANGES

FORM NUMBER - 032-03-823B

PURPOSE AND USE OF FORM – May be completed by the eligibility worker to document changed information and partial eligibility evaluations.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form is to be kept in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information for the case at the top of the form.

The eligibility worker may complete the form to record changed elements and to document the impact of the change(s) on the household's eligibility.



**SNAP – HOTLINE INFORMATION**

**NAME OF APPLICANT:** \_\_\_\_\_

**YOUR DATE OF APPLICATION:** \_\_\_\_\_

**THE DATE THE AGENCY MUST GIVE YOU  
YOUR SNAP BENEFITS OR A DECISION:** \_\_\_\_\_

IF THIS BOX IS CHECKED, YOUR APPLICATION IS ENTITLED TO EXPEDITED SERVICE  
(7-DAY SERVICE)

If you don't get your SNAP benefits or a decision by this date, you should call the Client Services Hotline for immediate help. The Hotline is open Monday through Friday, except holidays, from 8:15 a.m. to 5:00 p.m. The numbers are:

For the Richmond Calling Area: **692-2198**

For the Rest of Virginia: **1-800-552-3431**

Once you have called this number, you must be told by the next business day that you are either eligible or ineligible. If you are told that you are eligible, SNAP benefits will be provided the next business day. However, if you call before 3:00 p.m. on Thursday or Friday and are eligible, SNAP benefits will be provided on the next business day.

If you are not satisfied with the action the local agency took on your application, or if there are other problems with your SNAP case, you may contact the local legal aid office in your area. Names and addresses of legal aid offices are on the back of this flyer.

In order to determine if you are eligible for SNAP benefits, the agency may ask you to verify certain information. If you have provided the required verifications, you should either have your SNAP benefits or receive a denial notice within 30 days from the day you filed your application.

If you are in an emergency situation, you should have your SNAP benefits within 7 days. This is called "expedited service." Your application will be given expedited service if:

- Your household's monthly income is less than \$150, and resources are \$100 or less; or
- Your total income and resources are less than your shelter bills; or
- A migrant or seasonal farm worker lives in your household, and you have little or no income or resources.

\_\_\_\_\_  
Name of Worker Completing This Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker's Telephone

The Virginia Department of Social Services is an Equal Opportunity Provider

**Call 1-866-LEGLAID (1-866-534-5243) Legal Aid Hotline  
or visit [www.valegalaid.org](http://www.valegalaid.org)**

Blue Ridge Legal Services, Inc.  
204 North High Street  
Harrisonburg VA 22803  
(540) 433-1830

Blue Ridge Legal Services, Inc.  
119 South Kent Street  
Winchester VA 22604  
540-662-5021

Blue Ridge Legal Services, Inc.  
203 North Main Street  
Lexington VA 24450  
540-463-7334

Blue Ridge Legal Services, Inc.  
132 Campbell Avenue, SW  
Suite 300  
Roanoke VA 24011  
540-344-2080

Central VA Legal Aid Society  
101 West Broad Street, Suite 101  
Richmond VA 23220  
804-648-1012

Central VA Legal Aid Society  
1000 Preston Ave, Suite B  
Charlottesville VA 22903  
(434) 296-8851

Central VA Legal Aid Society  
10-A Bollingbrook  
Petersburg VA 23803  
804-862-1100

Legal Aid Society of Eastern Virginia  
125 St. Paul's Boulevard, Suite 400  
Norfolk VA 23510  
757-627-5423

Legal Aid Justice Center  
1000 Preston Avenue, Suite A  
Charlottesville VA 22903  
(434) 977-0553

Legal Aid Justice Center  
123 East Broad Street  
Richmond, VA 23219  
804-643-1086

Legal Aid Justice Center  
37 Bollingbrook Street  
Petersburg, VA 23803  
804-862-2205

Legal Aid Society of Eastern Virginia  
291 Independence Blvd.  
Pembroke Four, Suite 532  
Virginia Beach, VA 23462  
757-552-0026

Legal Aid Society of Roanoke Valley  
416 Campbell Avenue SW  
Roanoke VA  
(540) 344-2088

Legal Aid Society of Eastern VA  
30 W. Queens Way  
Hampton VA 23669  
757-275-0080

Legal Aid Society of Eastern VA  
199 Armistead Avenue  
Williamsburg VA 23185  
757-220-6837

Legal Aid Society of Eastern VA  
36314 Lankford Highway, Suite 5  
Belle Haven VA 23306  
757-442-3014

Legal Services of Northern VA  
6066 Leesburg Pike, Suite 500  
Falls Church VA 22041  
703-778-6800

Legal Services of Northern VA  
603 King Street, 4<sup>th</sup> Floor  
Alexandria VA 22314  
703-684-5566

Legal Services of Northern VA  
1916 Wilson Boulevard, Suite 200  
Arlington VA 22201  
(703) 532-3733

Legal Services of Northern VA  
4080 Chain Bridge Road  
Fairfax VA 22030  
703-246-4500

Legal Services of Northern VA  
109 N. King Street, SW  
Leesburg VA 20176  
703-777-7450

Legal Services of Northern VA  
9240 Center Street  
Manassas VA 20110  
703-371-1105

Rappahannock Legal Services, Inc.  
618 Kenmore Avenue, Suite 1-A  
Fredericksburg VA 22401  
540-371-1105

Rappahannock Legal Services, Inc.  
146 North Main Street  
Culpeper VA 22701  
540-825-3131

Legal Services of Northern VA  
8305 Richmond Highway, Suite 17B  
Alexandria, VA 22309  
703-778-3448

Southwest VA Legal Aid Society, Inc.  
155 Arrowhead Trail  
Christiansburg VA 24073  
540-382-6157

Southwest VA Legal Aid Society, Inc.  
227 West Cherry Street  
Marion VA 24354  
(276) 783-8300

Rappahannock Legal Services, Inc.  
407 Prince Street  
Tappahannock VA 22560  
(804) 443-9393

Virginia Legal Aid Society  
513 Church Street  
Lynchburg VA 24504  
434- 846-1326

Virginia Legal Aid Society  
105 S. Union Street, Suite 400  
Danville VA 24541  
804-799-3550

Southwest VA Legal Aid Society, Inc.  
16932 West Hills Drive  
Castlewood VA 24224  
(276) 762-9356

Virginia Legal Aid Society, Inc.  
155 E. Washington Street  
Suffolk VA 23434  
757-539-3441

Virginia Legal Aid Society, Inc.  
412 South Main Street  
Emporia VA 23847  
804-634-5172

Virginia Legal Aid Society, Inc.  
104 High Street  
Farmville VA 23901  
804-392-8108

Legal Services Corp. of Virginia  
700 E. Main Street, Suite 1504  
Richmond, VA 23219  
(804) 782-9438

Virginia Poverty Law Center, Inc.  
700 E. Franklin Street, Suite 14T1  
Richmond, VA 23219  
(804) 782-9430

SNAP - HOTLINE INFORMATION

FORM NUMBER - 032-03-0819

PURPOSE AND USE OF FORM - To inform each new or reapplying household of the time frame the agency has to process its application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The agency must complete the form and give it to the household on the day of application for benefits for any period for which the household has not already received benefits, i.e., new application, reapplication, or late recertification. The agency must mail the form if the household filed the application by mail.

INSTRUCTIONS FOR PREPARATION OF FORM -

The local agency must complete all blanks on the form.

Enter the name of the person filing the application at "Name of Applicant."

Enter the date the household filed the application at "Your Date of Application."

At "The Date the Agency Must Give You Your SNAP Benefits or Decision," enter the date that is 30 days from the date of application, unless the applicant is entitled to expedited service. If expedited service is appropriate, enter 7 days from the application date.

If the application is expedited, the worker must check the block indicating that entitlement.

Enter the information requested at "Name of Worker Completing This Form."

The worker must circle the name and number of the legal aid office serving the locality on the back of the flyer.



**DEPARTMENT OF SOCIAL SERVICES  
Supplemental Nutrition Assistance Program (SNAP)**

**KNOW YOUR RIGHTS WHEN APPLYING FOR SNAP Benefits**

If you are interested in applying for SNAP benefits, here is information you need to know:

Persons applying for SNAP benefits must file an application by submitting the application form to the Department of Social Services in the county or city where they live, either in person, through an authorized representative, by fax, online, or by mail.

You have the right to file an application on the same day you contact the Department of Social Services in your locality. The address and hours of the office are shown at the bottom of this notice. Your application may be submitted any time during office hours.

You may come to the office to pick up an application any time during office hours, or the agency can mail you an application on the same day you request it.

If your resources and income are very low (\$100 in resources and \$150 in income), or you are a migrant or seasonal farm worker, or your combines gross monthly income and resources are less than your family's shelter expenses, you may be eligible for expedited service. This means that if you are eligible, you are entitled to receive benefits within 7 days following the date your application is filed at the local social services department.

Your Application will be reviewed on the day it is received for possible eligibility for expedited service.

You have the right to file an application even if you appear to be ineligible for the program.

You or a designated authorized representative may file an incomplete application as long as it contains a name, address, and signature of a responsible household member or properly designated authorized representative. The agency has 30 days to process your application (7days, if expedited). The 30-day (or 7-day, if expedited) processing time begins the day after the application is received at the office. Additionally, your SNAP benefits for the month of application will be prorated from the date of application if you are found eligible.

If your case is approved, you must receive your benefits within 30 days following the date of application (or 7 days, if expedited)

As part of the SNAP application process, you must have an interview before you are certified. The interview is not necessary before you file the application. The interview may be held in the office or by telephone.

SNAP has separate rules and processes from other programs. You should apply for SNAP benefits even if there are limitations on receiving benefits for other programs.

**YOU ARE ENCOURAGED TO APPLY FOR SNAP BENEFITS THE SAME DAY YOU CONTACT THE AGENCY FOR ASSISTANCE.**

AGENCY NAME:

ADDRESS:

PHONE NUMBER:

OFFICE HOURS:

SNAP is administered without regard to age, race, color, sex, disability, religion, national origin, or political beliefs. The Virginia Department of Social Services is an equal opportunity provider.

KNOW YOUR RIGHTS WHEN APPLYING FOR SNAP BENEFITS

FORM NUMBER - 032-03-0821

PURPOSE OF FORM - To consolidate information the local agency must share with an applicant for SNAP benefits. The form is optional.

USE OF FORM - May be given to applicants requesting SNAP information instead of a verbal explanation of applicants' rights. The agency must advise applicants that the form is a listing of program rights. The agency must also ensure that the applicant is able to read the form in English and comprehend it.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The flyer may be given to applicants inquiring about SNAP benefits.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the bottom of the form, supplying the local agency's name, address, telephone number, and office hours.

**EXPEDITED SERVICE CHECKLIST**

NAME: \_\_\_\_\_

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

I.  YES  NO Has anyone for whom you are applying received SNAP benefits this month?

If YES, who: \_\_\_\_\_

where: \_\_\_\_\_

II. INCOME BEFORE DEDUCTIONS this month for everyone in your household. Count money already received plus any money expected to be received during this month.

Type of Income

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

III. RESOURCES for everyone in your household:

Cash on Hand \$ \_\_\_\_\_

Checking Accounts \$ \_\_\_\_\_

Savings Accounts \$ \_\_\_\_\_

IV. SHELTER EXPENSES this month.

Rent/Mortgage \$ \_\_\_\_\_

Utility expenses this month \$ \_\_\_\_\_

Which utilities do you pay? (check all that apply)

Heat  Lights  Telephone

Electricity for Air Conditioning  Sewer

Garbage  Other

V.  YES  NO Is anyone in your household a Migrant or a Seasonal Farm worker?

AGENCY USE ONLY

1.  YES  NO Is income less than \$150 AND resources \$100 or less?

IF YES, EXPEDITE

2.  YES  NO Is income plus resources less than shelter?

Income \$ \_\_\_\_\_

Resources +\$ \_\_\_\_\_

Total \$ \_\_\_\_\_

Shelter \$ \_\_\_\_\_

IF YES, EXPEDITE

NOTE: If the household is entitled to the Utility Standard, apply the Standard to determine Shelter, unless the household chooses to use actual shelter costs.

FOR MIGRANT & SEASONAL FARMWORKERS

3A.  YES  NO Are resources \$100 or less AND, in the next 10 days, \$25 or less is expected from new income source?

IF YES, EXPEDITE

3B.  YES  NO Are resources \$100 or less AND no income is expected from a terminated source this month or next month?

IF YES, EXPEDITE

DETERMINATION

EXPEDITED  NOT EXPEDITED

Screened by:

EXPEDITED SERVICES CHECKLIST

FORM NUMBER - 032-03-0718

PURPOSE OF FORM - To assist agencies in screening households for entitlement to expedited services.

USE OF FORM - To be completed, as needed, at the time of a new application, reapplication or a late recertification to identify households who are eligible for expedited services.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - File in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Obtain the information on the left side of the form from the applicant. The applicant, eligibility worker, screener, volunteer, or anyone else designated by the agency, may complete the left side of form.

Agency personnel must complete the "Agency Use Section." The form identifies each of the ways a household could be eligible for expedited service. If a household is entitled to expedited services, the EW must conduct an interview, determine eligibility, and authorize benefits, if eligible, within the expedited service time frames.

NOTE: This form will assist in screening households for expedited services. Agencies that use appointment systems for interviews must screen all applicants to ensure that those entitled to expedited services are given appointments and delivered benefits within expedited time frames. Agencies that interview clients on a walk-in, daily basis may not necessarily need to use this checklist since determination for expedited service can be made during the interview.

**CHECKLIST OF NEEDED VERIFICATIONS**

Name
Address

Case Number	
Program(s)	Date
Worker	Telephone

In order to receive assistance, you must provide the information checked below. We will help you obtain the information. If you cannot provide the information, or if you need help in providing the information, contact your worker. Call collect, if necessary. IF YOU DO NOT PROVIDE THIS INFORMATION OR CONTACT THE AGENCY BY THE FOLLOWING DATES, YOUR APPLICATION MAY BE DENIED.

TANF: \_\_\_\_\_ SNAP: \_\_\_\_\_  
 MEDICAID: \_\_\_\_\_ OTHER: \_\_\_\_\_

1. INCOME (Earned and Unearned) for \_\_\_\_\_
- Pay stubs
  - Statement from employer
  - Self-employment records
  - Social Security/SSI benefits
  - VA benefits
  - Retirement income
  - Child support, alimony payments
  - Unemployment benefits
  - Worker's Compensation benefits
  - Loans (personal or education)
  - (fl) Scholarships, (BEOG, PELL, SEOG, CSAP, or other)
  - Work-study pay stubs
  - Other \_\_\_\_\_

2. WORK OR SCHOOL EXPENSES
- Day care expenses for child or adult
  - School expenses (tuition, fees, books, supplies, transportation, or other)
  - Other \_\_\_\_\_

3. RESOURCES
- Checking, savings, credit union, Christmas Club account statements
  - Stocks, bonds or CDs
  - Pension plans, retirement accounts, IRAs
  - Burial plots, funds, contracts
  - Real estate property
  - Title, registration, or personal property tax receipt for motor vehicles, motor boats, motor homes

- Life insurance policies
- Other \_\_\_\_\_

4. SHELTER EXPENSES
- Rent or mortgage receipt
  - Real estate taxes
  - Homeowner's insurance
  - Electric bill
  - Gas/Kerosene/oil/wood bill
  - Water/sewage bill
  - Garbage bill
  - Phone bill
  - Initial installation charge
  - Other \_\_\_\_\_

5. LEGALLY RESPONSIBLE RELATIVE
- Income verification
  - Statement of contribution
  - Child support or alimony
  - Extraordinary expenses
  - Proof of continued absence
  - Copy of support order
  - Other \_\_\_\_\_

6. WORK REGISTRATION
- Registration information

7. IDENTITY
- Driver's license
  - Voter registration card
  - Clinic, medical card
  - Work ID, school ID, library card
  - Other \_\_\_\_\_

8. RESIDENCY, LIVING ARRANGEMENTS, SCHOOL ENROLLMENT
- Verification of residence
  - Verification of child(ren) living in the home
  - School enrollment
  - Separate arrangements to buy and prepare food
  - Other \_\_\_\_\_

9. DOCUMENTS
- SSN Cards/numbers
  - Application for SSN card
  - Declaration of citizenship
  - Immigrant/Alien documentation
  - Birth verification
  - Verification of paternity
  - Marriage certificate
  - Divorce decree
  - Death certificate
  - Deprivation statement
  - Other \_\_\_\_\_

10. MEDICAL INFORMATION
- Assignment of Rights form
  - Medical form, statements
  - Pregnancy statement
  - Health insurance policies, cards
  - Medicare card
  - Health insurance premiums
  - Medical bills for
  - Prescription drug bills
  - HIPP forms
  - Immunization records
  - Other \_\_\_\_\_

Other information or verification needed: \_\_\_\_\_

CHECKLIST OF NEEDED VERIFICATIONS

FORM NUMBER - 032-03-0814

PURPOSE OF FORM - To advise households of verifications needed to process their applications.

USE OF FORM - To be completed by the eligibility worker and given to the applicant to meet the requirement that households receive written notice of verification requirements. The form is required for SNAP. It may be used to inform applicants of verifications needed for other programs.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is given to the household. The agency retains a copy with the SNAP application and a copy may be filed with applications for other benefits.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Complete the sentence "Please provide information by: \_\_\_\_\_" with the date by which verification is needed. This date would be 10 days from the interview date or other date when the household was told what was needed. No action may be taken to deny the application before the 30<sup>th</sup> day after the request date if verification is not provided by the 10th day.

In the body of the form, check the items requiring verification.

Use the blank lines at the bottom of the form for additional information or instructions. For example, for expedited applications, information not available during the interview can be noted with instructions to submit the information within seven days following the application date. The form must still indicate the verifications needed for normal processing however.

# NOTICE OF ACTION

THIS IS TO INFORM YOU OF ACTION TAKEN ON YOUR SNAP APPLICATION/CASE.

CASE NUMBER
DATE
COUNTY/CITY

## SECTION 1. ACTION ON APPLICATION DATED \_\_\_\_\_

- Approved for following months \_\_\_\_\_  
Amount first month \$ \_\_\_\_\_ Month covered \_\_\_\_\_ Amount for following months \$ \_\_\_\_\_  
You selected \_\_\_\_\_ as Head of Household. If all adult members do not agree, contact your worker in 10 days.  
**NOTE:** If you applied for both SNAP and TANF or GR at the same time, and then are approved for TANF or GR benefits, your SNAP amount may be reduced without advance notice.
- If this box is checked, your application was approved even though some verification was postponed. We need the following information or verification from you: \_\_\_\_\_

If we do not receive these by \_\_\_\_\_ your case will be closed effective \_\_\_\_\_

If this verification results in changes in your household's eligibility or amount of benefits, we will make such changes without advance notice.

- Denied. If your application was denied because of your failure to provide proof/information, we will reopen your application if you provide the information by \_\_\_\_\_. See Section 3
- Continue to hold application pending. The cause for delay is:
- Agency delay. Your application will be processed as soon as possible.
  - Client delay.
  - We are waiting for the following information from you: \_\_\_\_\_  
We must have this information by \_\_\_\_\_ or your application will be denied.

## SECTION 2. ACTION ON SNAP CASE

- Changed from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ effective \_\_\_\_\_  
 If this box is checked, we must receive the following verification from you: \_\_\_\_\_  
We must receive this verification by \_\_\_\_\_. If your allotment was increased but we do not receive this verification, your benefits will go back to the amount \$ \_\_\_\_\_ effective \_\_\_\_\_ without advance notice.
- Reinstated - - Amount \$ \_\_\_\_\_ effective \_\_\_\_\_
- Supplemented - - Amount \$ \_\_\_\_\_ for the month of \_\_\_\_\_
- Suspended for the month of \_\_\_\_\_
- Terminated effective \_\_\_\_\_

## SECTION 3. ACTION ON SNAP CASE

Manual Reference: \_\_\_\_\_

**YOU MUST REPORT IF YOUR HOUSEHOLD'S INCOME GOES OVER THE LIMIT OR IF YOUR ADDRESS CHANGES.** If necessary, you may call collect.

Children approved for SNAP benefits and attending public school may be eligible for free meals. Call your school for more information.

If you do not agree with the action we have taken or the amount of SNAP benefits you are receiving, you may have a fair hearing on your case. You must request your fair hearing within the next 90 days. If you appeal the action on your case before \_\_\_\_\_ assistance may continue. However, if assistance is continued, you may have to repay SNAP benefits you received during the appeal process if the hearing decision supports the agency action. For additional information about appeals and fair hearings, please see the back of this notice.

Worker	Telephone Number	For Free Legal Advice Call <b>1-866-534-5243</b>
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## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901
- Call me at the number listed on the front
- Call 1-800-552-3431

### When to Appeal

- Within the next 90 days.
- Within 10 days of the date on this form to get the SNAP benefits continued.\*

\* Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end you SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal within 10 days of the SNAP conference. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your SNAP benefits, you may continue to receive benefits until there is a hearing decision. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Questions or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

10/09

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NOTICE OF ACTION

FORM NUMBER - 032-03-0117

PURPOSE OF FORM - To notify an applicant/recipient of eligibility action taken on an application or an ongoing food stamp case.

USE OF FORM - To be prepared and sent immediately or within the appropriate time standard following action on an application or a SNAP case unless ADAPT notices are used.

The Notice of Action may be used in place of the Advance Notice of Proposed Action for SNAP only cases. It is to be used in all instances where policy requires the use of an "adequate notice".

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original must be sent to the head of the household. One (1) copy is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form.

SECTION 1

Use this section to inform the household of the disposition of an application, reapplication or recertification.

Enter the date of the application.

Check the appropriate box to show the disposition of the application.

For approvals, indicate the months of certification, the amount of benefits and months covered by the first issuance, and the amount for following months.

For application denials, note the deadline for submitting verification/information if the application is denied before the end of processing period.

If the application was expedited and verification was postponed, check the box which says "If this box is checked...." List the postponed verification, the date by which the verification is needed, and the effective date of closure if the verification is not received. The deadline date for submitting the verifications will be the 30th day after the application filing date and the closure date will be the last day of the month of application for applications filed before the 15th day of the month. For applications filed on or after the 16th day of the month, the verification deadline and closure date will be the last day of the month after the month of application.

For applications which must be held pending an additional 30 days, check whether the delay was caused by the agency or household. If information is still needed, indicate the missing information and date by which information is needed to prevent denial.

TRANSMITTAL #1

SECTION 2

Use this section to inform the household of action taken on an ongoing SNAP case.

Check the appropriate box to show a change in an allotment, a reinstatement, a supplement, a termination or a suspension. An "other" block is also provided for situations that may not be covered by the choices listed.

If verification is needed of a change, check the indented block which explains that verification must be received or the allotment will revert to the previous amount. Complete blanks as needed for the specific situation.

SECTION 3

Use this section to explain the reason for the action taken or to give a further explanation of any of the items checked in Sections 1 or 2.

Complete the information at the bottom of the form. A date must be entered in the space provided in the appeal information section whenever the form is sent for negative actions to reduce, terminate, or to suspend benefits. A date must not be entered when the form is sent for approvals or denials of applications.

Enter the SNAP Manual Reference.

Case number	Program
Date of Mailing:	
Call <b>1-866-534-5243</b> , Legal Aid Hotline, for free legal assistance.	

**ADVANCE NOTICE OF PROPOSED ACTION**

**ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.**

<input type="checkbox"/> <b>SNAP Benefits</b>				Your SNAP allotment will be:	<input type="checkbox"/> Reduced	<input type="checkbox"/> Suspended	<input type="checkbox"/> Terminated
Effective Date:	Amount of reduction:	Eligibility Worker:	Telephone:	From:	To:		
Reason for Proposed Action:							
Manual Reference							

<input type="checkbox"/> <b>FINANCIAL ASSISTANCE</b>				Your assistance check will be :	<input type="checkbox"/> Reduced	<input type="checkbox"/> Suspended	<input type="checkbox"/> Terminated
Effective Date:	Amount of Reduction:	Eligibility Worker:	Telephone:	From:	To:		
Manual Reference:				Reason for proposed action:			
<input type="checkbox"/> VIEW Termination – The TANF case is closed until you reapply and are found eligible for TANF/TANF-UP <input type="checkbox"/> VIEW Sanction - your household's entire TANF or TANF-UP benefits will be suspended for the above reason. <input type="checkbox"/> 1 <sup>ST</sup> Sanction - 1 month and compliance <input type="checkbox"/> 2 <sup>ND</sup> Sanction - 3 months and compliance <input type="checkbox"/> 3 <sup>RD</sup> Sanction - 6 months and compliance <b>YOU HAVE 10 DAYS AFTER THE DATE OF THIS NOTICE TO CONTACT YOUR VIEW WORKER TO SHOW DOCUMENTED GOOD CAUSE.</b>							
VIEW worker's name				Telephone:			
<input type="checkbox"/> While your TANF payment is suspended, any support paid to the Division of Child Support Enforcement (DCSE) in the month of suspension for you or your dependents will be mailed to you. You will <u>not</u> receive a TANF Match Payment for any month in which support was mailed to you while your TANF case was suspended. If your case is reinstated, any support paid to the DCSE for you or your dependents will be kept by the state to repay TANF assistance received by your family.							
<input type="checkbox"/> If there is someone who is supposed to pay support for you or your dependents, you will continue to receive support enforcement services unless you send written notice that you do not want this service to the Division of Child Support Enforcement. You can obtain their address and telephone number from your local social services agency.							

<input type="checkbox"/> <b>MEDICAID, FAMIS PLUS OR STATE/LOCAL HOSPITALIZATION (SLH)</b>			
<input type="checkbox"/> No longer eligible for full Medicaid. Approved for limited Medicaid coverage: Qualified Medicare Beneficiary (QMB)      Special Low-Income Medicare Beneficiary (SLMB)      Qualified Individual (QI)			
<input type="checkbox"/> No longer eligible for Medicaid. <input type="checkbox"/> No longer eligible for FAMIS PLUS. <input type="checkbox"/> No longer eligible for SLH.			
<input type="checkbox"/> No longer eligible for payment of long-term care because of transfer of assets.			
Effective date	Manual reference:	Eligibility worker:	Telephone:
Ineligible family members:			
Reason for proposed action:			
<input type="checkbox"/> Income exceeds the full Medicaid limit. If medical or dental expenses of \$ _____ are incurred between _____ and _____ or medical or dental expenses of \$ _____ are incurred between _____ and _____, bringing your bills to this agency and your eligibility will be reviewed.			
<input type="checkbox"/> Other: _____			

If you disagree with the action we have proposed, you may ask for a conference or appeal the decision. If you appeal this action Before \_\_\_\_\_, the change will not go into effect and your benefits for SNAP, General Relief, or Auxiliary Grant Program may continue until a hearing officer makes a decision. If you appeal before \_\_\_\_\_ for actions for the TANF, Refugee Assistance, Medicaid, FAMIS PLUS or SLH Program, the assistance may continue. You may have to repay any assistance you get during the appeal process if the hearing decision supports the action we propose. You may appeal the decision proposed in this notice up to 30 days of this notice or by the effective date for TANF, Refugee Assistance, Medicaid, FAMIS PLUS or SLH actions. You may appeal General Relief or Auxiliary Grant Program actions within 30 days of this notice. You may appeal food stamp actions within 90 days of this notice. See the back of this notice for additional information about appeals and fair hearings.

## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a hearing on your case. You will have a chance to explain why you think we made a mistake at the hearing and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services (DMAS).

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request for Medicaid, FAMIS PLUS, or SLH appeals to Client Appeal Division, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.
- Send a written request for financial assistance and SNAP benefits appeals to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901 or call me at the number listed on the front, or call 1-800-552-3431

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for financial assistance benefits within two days following the date of the conference and within 10 days of the SNAP conference. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or SNAP benefits, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you receive during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request. You will get the hearing officer's decision within 90 days of the date the Department of Medical Assistance Services receives your appeal request for Medicaid, FAMIS PLUS, or SLH appeals.

## HIPAA PORTABILITY RIGHTS

Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. You may request a "Certificate of Creditable Coverage" for your coverage by visiting the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) or contacting the Helpline at 804-786-6145.

ADVANCE NOTICE OF PROPOSED ACTION

FORM NUMBER - 032-03-0018

PURPOSE OF FORM - (1) To notify a household of a reduction, termination or suspension of benefits which occurs within the certification period; and, (2) to advise the household of its right to a local agency conference and its right of appeal to the State agency.

USE OF FORM - (1) To be prepared immediately following the decision of the local agency that the above action is indicated; and, (2) to be mailed to the recipient immediately or as soon as possible after such decision.

This form may be used to advise recipients of simultaneous decreases or terminations in more than one program. Mandates for joint use in Public Assistance and SNAP are contained in Part XIV.A.3. of this manual and in Section 401.4 of the TANF Manual.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original must be issued to the head of the household. One (1) copy is to be retained in the SNAP case file and one (1) copy is to be placed in another program file, if appropriate.

INSTRUCTIONS FOR PREPARATION OF FORM - Enter the appropriate identifying information at the top of the form. Enter the case numbers and categories related to the proposed action.

For each program section, enter, as appropriate:

- a. Action Type
- b. Reason for Proposed Action
- c. Manual Reference
- d. Worker's Name and Telephone Number
- e. Amount of Reduction - Enter the former and new assistance or allotment amounts.
- f. Effective Date - Enter the date of the proposed action. This date must be at least 11 days after the date the form is mailed.

Examples

- (1) An Advance Notice of Proposed Action is mailed on October 15; the effective date of proposed action would be November 1.
- (2) An Advance Notice of Proposed Action is mailed on October 25; the effective date would be December 1.

MEDICAID SECTION -

- a. When it is established that a recipient or any member of a recipient's family unit is ineligible for Medicaid for reasons other than income in excess of the established amount:

- 1) Enter the effective date of the proposed action.
  - 2) Ineligible Members - Enter the names of all ineligible individuals.
- b. When it is established that an otherwise eligible recipient or family unit is ineligible due to income in excess of the established amount:
- 1) Enter the amount of the excess income which must be spent or incurred in medical expenses before eligibility can be established.
  - 2) Enter the date which identifies the end of the appropriate six-month spend down which begins the first day of the month of termination.

APPEALS -

- a. For SNAP and Financial Services actions, enter the date that is 11 days after the date of mailing to indicate the date before which a timely appeal can be filed.
- For Medicaid actions, enter the effective date of the proposed action to indicate the date before which a timely appeal can be filed.
- b. Enter the effective date of the proposed action.

**Notice of Expiration**

To: \_\_\_\_\_  
\_\_\_\_\_

SNAP Case Number
County/City
Department of Social Services
Address
City, State, Zip
Telephone Number

Your SNAP eligibility will end on:
------------------------------------

Your eligibility for SNAP benefits is expiring. For uninterrupted benefits, you must file a new application by \_\_\_\_\_, have an interview, and be found eligible based on the information you give. If you do not file an application by this date, there may be an interruption in your benefits.

We can only start the renewal process once you file an application. You or your authorized representative may file an application that has at least your name, address, and your signature:

- in person at the address shown above or below;
- by mail, fax, by e-mail; or
- online at [www.vafood.org](http://www.vafood.org).

- in the office
- by telephone

You must have an interview. We have scheduled an appointment for an interview on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m. If this interview appointment is not convenient, please let us know immediately. If you miss this interview appointment, it will be your responsibility to reschedule it.

In addition to the application and interview, you must give us proof of your income, expenses, or other information to help us make a decision on your application. Please have your information available when you file the application or have your interview.

If a telephone interview is scheduled, you must:

- complete the enclosed application form;
- return the completed application by \_\_\_\_\_ to the address above or below;
- provide a telephone number where you can be reached during the scheduled time.

If you do not agree with the action taken on your application, you may appeal the action. You must file your appeal within ninety days of the agency's notice to you. You may get an appeal form from this department or from the Virginia Department of Social Services, 801 East Main Street, Richmond, VA 23219-2901, or you may call 1-800-552-3431.

If everyone in your house receives Supplemental Security Income (SSI) or plan to apply for SSI, you may renew your eligibility for SNAP benefits at the Social Security (SSA) office instead of filing your application at the local social services department. The Social Security office must also receive your application by the date indicated above.

The Virginia Department of Social Services is an equal opportunity provider.

Alternate Agency Address:

Eligibility Worker	Date	<input type="checkbox"/> Mailed <input type="checkbox"/> Given
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NOTICE OF EXPIRATION

FORM NUMBER - 032-12-0157 (The version presented here does not match the version prepared monthly by the Home Office with specific case information. This version may be used manually by local agencies.)

PURPOSE OF FORM - To advise the household (1) that its certification period is about to expire; and, (2) that a new application is necessary to establish further entitlement.

USE OF FORM - Households approved in the last month of their certification period, i.e., households certified retroactive to a previous month(s), must have the expiration notices at the time of certification. All other households must have the expiration notices no later than the last day of the next to the last month of the current certification period, but not earlier than the first day of the next to the last month of the current certification period. When the agency mails the Notice of Expiration, allow two days for delivery in addition to the postmark date. The Notice of Expiration will run on the 8<sup>th</sup> of the month. If the 8<sup>th</sup> is on a Friday, weekend or holiday, the Notice of Expiration will run on the last working day before the Friday, weekend or holiday.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must give or mail the original Notice of Expiration to the head of the household. One (1) copy remains in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete all blanks.

Below the agency's address enter the date the certification period will end, which is the last day of the last month of certification, in the space provided. Enter an alternate address for the agency at the bottom of the form, if appropriate.

Enter the date by which the household must file an application for recertification. For households approved in the last month of their certification period, this will be 15 calendar days from the date the notice will be received. (Allow two days for mailing in addition to the postmark date.) For all other households, this will be the 15<sup>th</sup> calendar day of the last month of certification.

Indicate whether the agency mailed or gave the form to the recipient on the date indicated.

Enter information regarding an interview date and time.

**CHANGE REPORT**

CASE NAME	CASE NUMBER
WORKER NAME	LOCALITY
AGENCY TELEPHONE NUMBER	

Use this form or call your worker to report changes listed below for your Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) case.

Report changes within 10 days of the day they occur; but at the latest, you have until the 10<sup>th</sup> day of the following month to report the change.

Note: If you have a Medicaid case, you must report **all** changes to your Medicaid worker within 10 days.

**ADDRESS CHANGE**

New Address (Street, Apt. Number)	City, State Zip	Telephone
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**GROSS INCOME FOR YOUR HOUSEHOLD GOES OVER THE LIMIT BELOW**

Number of People in your Household	Monthly	Weekly	Every 2 weeks	Twice a month
1	\$1,174	\$273.02	\$ 546.04	\$ 587.00
2	1,579	367.20	734.41	789.50
3	1,984	461.39	922.79	992.00
4	2,389	555.58	1,111.16	1,194.50
5	2,794	649.76	1,299.53	1,397.00
6	3,200	744.18	1,488.37	1,600.00
7	3,605	838.37	1,676.74	1,802.50
8	4,010	932.55	1,865.11	2,005.00
For each additional member add	+ \$406	+ \$94.41	+ \$188.83	+ \$203.00

These amounts are good through 9/30/10.

Add gross income for all the people in your household.      New income total \$ \_\_\_\_\_

**IF YOU RECEIVE TANF, TELL US IF AN ELIGIBLE CHILD LEAVES YOUR HOME**

Name	Date moved out	Name	Date moved out
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**CHANGES THAT MAY AFFECT VIEW PARTICIPATION FOR TANF. DISCUSS WITH YOUR VIEW WORKER.**

Change that has occurred \_\_\_\_\_

## CHANGES YOU MAY WANT TO REPORT

### CHANGE IN SHELTER EXPENSES

Rent or Mortgage	Property Taxes	Homeowner's Insurance	Electricity
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
Gas	Oil	Kerosene, Coal, wood, etc. List and give amount	
\$ _____ per _____	\$ _____ per _____		
Water/Sewer	Garbage	Telephone (Basic Service Only)	Installation Fees
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

### CHANGE IN DAY CARE EXPENSES

Person paying for care	Person receiving care	Amount billed	How often?
		\$ _____	

### CHANGE IN MEDICAL EXPENSES FOR MEMBERS WHO ARE 60 OR MORE OR DISABLED

Name	Type of expense	Amount billed
		\$ _____

### CHANGE IN LEGALLY OBLIGATED CHILD SUPPORT PAID TO ANOTHER HOUSEHOLD

Person paying support	Person receiving support	Amount legally obligated	Amount paid
		\$ _____ per _____	\$ _____ per _____

### CHANGE IN THE NUMBER OF PEOPLE IN YOUR HOUSEHOLD

Has ANYONE MOVED IN?

Name	Date moved in	Relationship to you	Social Security Number
Date of Birth	Race (not required)	Sex	Marital Status
U.S. Citizen Yes ( ) No ( )	If Alien, give alien number, date of entry	Last school grade completed	Currently in School? Yes ( ) No ( )

HAS ANYONE MOVED OUT?:

Name	Date moved out	Name	Date moved out

## HOW LONG DO YOU EXPECT THE CHANGE(S) TO CONTINUE

( ) YES ( ) NO Do you expect any of the change(s) you listed on this report to continue beyond this month? If YES, explain

I declare that all information I gave on this form is correct and complete to the best of my knowledge and belief.

Signature \_\_\_\_\_ Date \_\_\_\_\_

The Virginia Department of Social Services is an equal opportunity provider.

CHANGE REPORT

FORM NUMBER - 032-03-051

PURPOSE OF FORM - To provide a recipient household with a method of reporting changes in circumstances.

USE OF FORM - Recipient households may use the form to report changes in circumstances. Households must report changes to the agency when they occur but no later than 10 days after the month of the change.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The agency must provide the Change Report to all households at the time of initial application and reapplication and at recertification if the income limits listed on the form have changed or if the household needs another form. The agency must also provide the Change Report form whenever the household returns a completed one or reports a change in the household size.

INSTRUCTIONS FOR PREPARATION OF FORM – The EW must complete information at the top of the form before providing the form to the household. The EW must also highlight the household size and income limit that applies to the household when the form is provided.



**ENTITLEMENT TO RESTORATION OF LOST BENEFITS**

[ ]  
 [ ]

CASE NUMBER	
DATE	
LOCALITY	WORKER

YOU ARE ENTITLED TO A RESTORATION OF BENEFITS BECAUSE YOUR PRIOR ALLOTMENT WAS INCORRECTLY CALCULATED OR YOU WERE DENIED IMPROPERLY.

TOTAL AMOUNT OWED \$ \_\_\_\_\_ MONTH(S) RESTORATION COVERS \_\_\_\_\_

REASON \_\_\_\_\_

\_\_\_\_\_

IF THIS BLOCK IS CHECKED, YOU WERE OVERISSUED SNAP BENEFITS, YOUR RESTORATION WAS REDUCED BY THE AMOUNT YOU WERE OVERISSUED.

AMOUNT YOU WERE OVERISSUED \$ \_\_\_\_\_ AMOUNT YOU ARE ENTITLED TO RECEIVE \$ \_\_\_\_\_

YOUR REQUEST FOR RESTORATION OF BENEFITS, DATED \_\_\_\_\_, WAS DENIED DUE TO

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY REQUEST A FAIR HEARING.

IF YOU WANT TO REQUEST A FAIR HEARING, YOU MUST DO SO WITHIN 90 DAYS FROM THE DATE OF THIS NOTICE.

FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, PLEASE SEE THE BACK OF THIS NOTICE.

ELIGIBILITY WORKER	TELEPHONE NUMBER	FOR FREE LEGAL ADVICE CALL <b>1-866-534-5243</b>
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## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the Virginia Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901.
- Call me at the number listed on the front.
- Call 1-800-552-3431

### When to Appeal

- Within the next 90 days.
- Within 10 days of the date on this form to get the SNAP benefits continued.\*

\*Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal within 10 days of the conference date for SNAP. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your SNAP benefits, you may continue to receive benefits until there is a hearing decision. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance agreements; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

ENTITLEMENT TO RESTORATION OF LOST BENEFITS

FORM NUMBER - 032-03-0153

PURPOSE OF FORM - To notify a household of its entitlement to restoration of lost benefits.

USE OF FORM - To be completed at the time the local agency determines a household is entitled to restoration of lost benefits, or denies a request for restoration.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM – Send a copy to the household and retain a copy in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM

Complete the identifying information at the top.

Check the first box to inform a household that it is entitled to a restoration. Complete the information requested on the form. If the restoration was offset against an amount which was previously overissued, check the small block in the second paragraph and complete the information requested.

Check the second box if the request for restoration is denied and complete the information requested.

Complete the information at the bottom of the form.



**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF SOCIAL SERVICES  
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)  
REQUEST FOR CONTACT**

TO: 

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Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

In order to determine your eligibility for SNAP benefits or your continued eligibility for SNAP benefits, you must provide the following information or take the following actions:

\_\_\_\_\_ Proof of your address  
 Verification Form Attached

\_\_\_\_\_ Proof of who lives in your household and relationship

\_\_\_\_\_ Proof of your household's income  
 Verification Form Attached

\_\_\_\_\_ Other \_\_\_\_\_

Please take the requested action by \_\_\_\_\_ or we will close your SNAP case or deny your application.

\_\_\_\_\_  
Eligibility Worker

\_\_\_\_\_  
Telephone number

Request for Contact

FORM NUMBER - 032-03-0148

PURPOSE OF FORM - To request a household provide clarification or verification of the household's circumstances.

USE OF FORM - The EW must complete the form to request clarification, verification, or action taken by an applying or participating household. The household must take the requested action within ten days. The EW must follow this form with an Advance Notice of Proposed Action or Notice of Action if the agency alters the household's eligibility or benefit level in response to the Request for Contact.

This form is not intended to amend the request for information or verification needed for an application. The EW should send a revised Checklist of Needed Verifications in this instance.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must mail the form to the household and retain a copy of the completed form.

INSTRUCTIONS FOR PREPARATION OF FORM - The worker must complete the general case information and note the specific request for which the household is responsible for completing. The worker must also include the deadline for the submission of the information that is ten days after the mailing date.

**Commonwealth of Virginia  
Department of Social Services  
REQUEST FOR ASSISTANCE**

**GENERAL INFORMATION**

This Request for Assistance is the first part of the application process and protects your application date. You must also complete the second part of the application process by (1) having an interview, or (2) completing an Application for Benefits form, or another appropriate Medicaid application.

With this Request for Assistance, you can begin the application process for one or more of the following assistance programs. You can also use this Request to request a Medicaid resource assessment for long term care.

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Refugee Cash Assistance
- Refugee Medical Assistance
- Emergency Assistance
- General Relief
- Medical Assistance:
  - Medicaid
  - FAMIS, FAMIS PLUS, FAMIS MOMS
  - State and Local Hospitalization

**COMPLETE AND ACCURATE INFORMATION**

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required, but if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help some else receive benefits, you could be arrested and prosecuted for fraud. You must also provide required verifications.

**Special Information for Medicaid/FAMIS PLUS Applicants**

Applicants for Medicaid who declare that they are U.S. citizens on the application must prove their citizenship and identify. You must show the social services worker a document that proves you are a U.S. citizen. You must also show photo identification or a document that identifies you. Social services will give you a list of documents that you can use. If you cannot provide this information, let the worker know right away so you can get help in trying to secure information. Your signature on the application can be used to establish the identity for a child under age 16. **These requirements do not apply to persons who: 1) receive Supplemental Security Income (SSI); 2) receive Social Security Disability Insurance (SSDI); 3) are Medicare beneficiaries; 4) are children in foster care; or 5) are children who receive Title IV-A Adoption Assistance payments.**

**SPECIAL INFORMATION FOR SNAP APPLICANTS**

You may begin the application process for SNAP benefits by completing this Request for Assistance or by completing only the information in the boxes below and providing at least your **name, address, and signature**. You must complete the rest of the application process before your eligibility can be determined.

You must also be interviewed in the office or by telephone. You may turn in this Request for Assistance before you are interviewed. This is important because if you are eligible for the month in which you apply, your SNAP amount will be based on the date you actually turn in your Request.

**EXPEDITED SERVICE FOR SNAP BENEFITS**

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible and your gross monthly income is less than \$150 and liquid resources are \$100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farmworker household with little or no income and resources. **GIVE THE INFORMATION REQUESTED IN THE BOXES BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE MAY BE DETERMINED.**

Total money expected this month before deductions	\$ _____
Total cash, money in checking/savings accounts, CDs	\$ _____
Total rent or mortgage for this month	\$ _____
Utility expenses for this month	\$ _____
Which utilities do you pay? (check all that apply)	
<input type="checkbox"/> Heat <input type="checkbox"/> Lights <input type="checkbox"/> Telephone <input type="checkbox"/> Electricity for Air Conditioning <input type="checkbox"/> Water <input type="checkbox"/> Sewer <input type="checkbox"/> Garbage <input type="checkbox"/> Other	
Is anyone in your household a migrant or seasonal farmworker? YES ( ) NO ( )	

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

## VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is incorrect, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the U.S. Citizenship and Immigration Services (USCIS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

## COMPLETING THE REQUEST FOR ASSISTANCE

If you need help completing this Request for Assistance, a friend or relative or your eligibility worker may help you. If you are completing this Request for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 6 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

## FILING A REQUEST FOR ASSISTANCE

You may turn in a partially completed Request for Assistance which contains at least your **name, address, and signature** (or the signature of your authorized representative), but you must complete the rest of the application process before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Request for Assistance before your interview.

You may return your Request for Assistance by mail, fax, or in person. If you return the form in person, you may turn it in any time during office hours the same day you contact your local social services agency. You have the right to file your Request for Assistance, even if it looks like you may not be eligible for benefits.

## Your SNAP Rights

In accordance with Federal law and U.S. Department of Agriculture policy, the Virginia Department of Social Services is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, age, disability, political beliefs or retaliation.

### AGENCY USE ONLY EXPEDITED SERVICE DETERMINATION

Income less than \$150 and  
Resources \$100 or less

YES ( ) NO ( )

**Income plus resources less than shelter bills**

YES ( ) NO ( )

For migrants or seasonal farmworkers:

Resources \$100 or less, and in next 10 days  
\$25 or less is expected from new income:

**OR**

Resources \$100 or less, and no income  
is expected from a terminated source for the rest of

**Commonwealth of Virginia  
Department of Social Services  
REQUEST FOR ASSISTANCE  
--- ADAPT ---**

AGENCY USE ONLY			
Case Name	Case Number(S)	Program(s)	Registration Number
Application Type	Locality	Worker	Caseload Number
Date Of Service Referral		Date Received	

1.

Applicant's Name	C/O Name	Phone Number (Home/Messages)
		(Work)
Residence Address (Include City, State And Zip)	Mailing Address (If Different)	Directions To Home

2. Check ( ) your household's primary language: ( ) English ( ) Spanish ( ) Cambodian ( ) Vietnamese ( ) French ( ) Farsi  
 ( ) Kurdish ( ) Arabic ( ) Japanese ( ) German ( ) Chinese ( ) Haitian-Creole  
 ( ) Somali ( ) Korean ( ) Laotian ( ) Other \_\_\_\_\_

3. LIST EVERYONE LIVING IN YOUR HOME even if you are not requesting assistance for that person. List yourself on the first line. If you are married, list your spouse on the second line. Then list everyone else. Provide the information requested for each person listed. Check (√) type of assistance requested for each person. If no assistance is requested, check NONE for that person. A Social Security Number and an Alien Registration Number do not have to be provided for any individual for whom assistance is not being requested. Please note that an application for TANF will also be an application for SNAP (food stamps). Check TANF - No SNAP if you do not want to apply for SNAP benefits.

Name First Mi Last Suffix (Jr., Sr.)	Sex M / F	Race (Not required) Select all that apply	Ethnicity (Not required)	Date Of Birth	Social Security Number	Alien Registration Number	SNAP (food stamps)	TANF	TANF - No SNAP	Medical Assistance	General Relief	Emergency Assistance	Auxiliary Grants	Refugee Cash Assistance	Refugee Medical Assistance	Medicaid Resource Assessment	None	This Person's Relationship To You	Agency Use Only Client Id
(Your Name)																			
(Your Spouse's Name, if your are married)																			

4. List anyone from #3 above who is pregnant or who is disabled: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. List anyone from #3 above who is requesting Medicaid who had medical treatment during the 3 months before this request: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. YES ( ) NO ( ) Have you or anyone for whom you are applying ever applied for or received or are currently receiving any benefits from a social services agency, including SNAP (Food Stamps), AFDC, TANF, Medicaid, Children's Health Insurance, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, Refugee Cash or Medical Assistance?

Person Who Applied for or Received Benefits	Under What Case Name	Type of Benefits Received
When	From What County or City of State	

7. YES ( ) NO ( ) Does anyone have any of the following emergencies? If **YES**, check (✓) the type of emergency and explain the cause.  
 ( ) Food ( ) Shelter ( ) Medical ( ) Clothing ( ) Other Emergency \_\_\_\_\_  
 Cause: \_\_\_\_\_

8. YES ( ) NO ( ) Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, child care needs, family planning, family violence, referrals to other community organizations, or other problems or concerns. If **YES**, explain.

Explain:

**BY MY SIGNATURE BELOW I DECLARE, UNDER PENALTY OF PERJURY, THAT ALL OF THE FOLLOWING ARE TRUE:**

I understand:

- All of the information in the GENERAL INFORMATION Section on pages 1 and 2.
- If I give false, incorrect, or incomplete information, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone else complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I received the Benefit Programs Booklet YES ( ) NO ( ) **MEDICAID APPLICANTS:** I received the Virginia Medicaid Handbook YES ( ) NO ( )

All information I gave on this Request for Assistance is correct and complete to the best of my knowledge and belief. I authorize the release to this agency of all information necessary to determine my eligibility.

I filled in this Request for Assistance myself. YES ( ) NO ( ) If **NO**, it was read back to me when completed. YES ( ) NO ( )

APPLICANT <u>OR</u> AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	WITNESS TO MARK <u>OR</u> INTERPRETER	DATE
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**COMPLETE THE BOX BELOW IF THIS REQUEST FOR ASSISTANCE WAS COMPLETED FOR THE APPLICANT BY SOMEONE ELSE:**

APPLICANT <u>OR</u> AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)	RELATIONSHIP TO APPLICANT	

REQUEST FOR ASSISTANCE

FORM NUMBER - 032-03-0875

PURPOSE OF FORM - To indicate an intent to apply for benefits by an applicant. If a telephone interview is planned, it is recommended that this form is not given to applicants for completion.

USE OF FORM - To be completed by an applicant to begin the application process through the ADAPT system. The form, completed with the applicant's name, address and signature, will secure the application date regardless of the eventual date of completion of the interactive interview and signed Statement of Facts or Application for Benefits. The form will also allow an evaluation of entitlement to expedited service processing.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form must be retained in the case record with the corresponding Statement of Facts or Application for Benefits.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.



**INTERIM REPORT FORM - REQUEST FOR ACTION**


Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

You were required to send in a completed Interim Report to this agency by the fifth (5<sup>th</sup>) of the month for your TANF and/or your SNAP case. Please note the information checked below.

( ) The Interim Report form you submitted was incomplete. The form you submitted is attached. This form is incomplete because:

1. ( ) You did not answer every question. Please answer the following questions:

\_\_\_\_\_

\_\_\_\_\_

2. ( ) You did not sign and/or date the report. Please sign and date the report.

( ) Proof of some of the statements made on your report was missing. Without the proof we are requesting, the amount of TANF or SNAP benefits you receive may not change or your case may be closed. Please send in the following proof:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

You must return a completed Interim Report and proof of any changes within ten (10) days. If you do not submit a completed report, your SNAP benefits or TANF case may close. **You will not receive an additional notice** unless the information you submit changes your benefits.

If you are unable to complete the Interim Report or if you have any questions about how to complete it or what information you need to send in, please ask for help.

**If you have taken the actions listed above, please disregard this reminder.**

Worker	Telephone Number	For Free Legal Advice Call <b>1-866-534-5243</b>
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## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a hearing on your case. You will have a chance to explain why you think we made a mistake at the hearing and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901.
- Call me at the number listed on the front.
- Call 1-800-552-3431.

### When to Appeal

- Within the next 30 days for TANF and within the next 90 days for SNAP benefits.
- Within 10 days of the date on this form to get the SNAP benefits continued.\*
- Before the effective date of the change to get the TANF benefits continued.\*

\*Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for TANF benefits within two days following the date of the SNAP conference and within 10 days of the conference date. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or SNAP benefits, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you receive during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearings officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearings officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

INTERIM REPORT FORM – REQUEST FOR ACTION

FORM NUMBER – 032-03-0649

PURPOSE OF FORM – To notify a household of required actions it must take for submitting the Interim Report or any needed verifications.

USE OF FORM – The agency may use this form to tell households what action is needed to process the Interim Report to avoid closure of the case.

NUMBER OF COPIES – Two

DISPOSITION OF FORM – The agency must notify households when they fail to complete the Interim Report form or fail to submit needed verification or information. If the household files an incomplete form or fails to submit needed information, the EW must return the original Interim Report to the household along with this action form.

INSTRUCTIONS FOR PREPARATION OF FORM – The EW must complete identifying case and agency information at the top of the form. The EW must complete the action required of the household and include a date for submitting the completed form or information/verification. The EW must sign and date the form.



**PERMANENT VERIFICATION LOG**

Case Name	Case Number	FIPS	EW	Date
Secondary Case Name	Secondary Case Number			

**DOCUMENT METHODS AND DATES OF VERIFICATION REQUIRED BY PROGRAM(S) BEING EVALUATED.**

**1. MEMBER INFORMATION**

MBR #	LAST	NAME FIRST	MI	SOCIAL SECURITY NUMBER (# or APP mm/dd/yy)	DATE OF BIRTH	CITIZENSHIP/ ALIEN STATUS	IDENTITY	RELATIONSHIP
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:
				VFN:	VFN:	VFN:	VFN:	VFN:

**INDICATE ANY CHANGES TO THE ABOVE INFORMATION AND DOCUMENT METHOD AND DATE OF VERIFICATION.**

**2. DOCUMENTS AND VERIFICATIONS (WHEN REQUIRED BY POLICY)**

**BIRTH RECORDS AND IMMUNIZATIONS**

Name	Date of Birth	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name		BVS#/VFN	
Immunizations, Dates				

Name	Date of Birth	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name		BVS#/VFN	
Immunizations, Dates				

Name	Date of Birth	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name		BVS#/VFN	
Immunizations, Dates				

Name	Date of Birth	Place Of Birth	Sex	Race
Mother's Maiden Name	Father's Name		BVS#/VFN	
Immunizations, Dates				

**MARRIAGE RECORDS**

Wife's Maiden Name		Husband's Name
Date of Marriage	Place	VFN

**DIVORCE RECORDS**

Husband		Wife
Date of Divorce	Place	VFN

**DEATH RECORDS**

Name of Deceased		
Date of Death	Place	VFN

PERMANENT VERIFICATION LOG

FORM NUMBER - 032-03-823A

PURPOSE OF FORM – May be used to document verification of eligibility factors which are generally not subject to change. The form is optional.

USE OF FORM – May be completed at initial certification, recertification or during the certification period if a change is reported

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The form may be kept in the case record. If additional space is needed, use an additional form.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form.

Document the method and date of verification for required elements for SNAP purposes.

Document changes to previously verified information and document the method and date of verification of the change.



COMMONWEALTH OF VIRGINIA  
 DEPARTMENT OF SOCIAL SERVICES  
 DIVISION OF BENEFIT PROGRAMS

<b>NON-RECEIPT AFFIDAVIT/EBT CARD REPLACEMENT REQUEST</b>		CASE NUMBER
CASE NAME	DATE	LOCALITY
ADDRESS	CITY, STATE, ZIP	

CHECK ( ) THE BOX BELOW WHICH DESCRIBES THE REPLACEMENT REASON:  <input type="checkbox"/> Non receipt of electronic benefits transfer (EBT) Card <input type="checkbox"/> Food destroyed in a household disaster  <input type="checkbox"/> EBT card destroyed/stolen	How was the EBT card or food destroyed or damaged?   
Value of destroyed food   	If the EBT card was stolen, have you filed a police report? <input type="checkbox"/> Yes <input type="checkbox"/> No  Where filed? _____ Date: _____

I hereby certify, under penalty of perjury and/or fraud, that the household listed above has not received its electronic benefits transfer (EBT) card or has experienced the destruction of food, the destruction of the EBT card, or has experienced the theft of an EBT card in the month of \_\_\_\_\_, (year)

\_\_\_\_\_

Signature	Date
-----------	------

**The Virginia Department of Social Services is an equal opportunity provider.**

Non-Receipt Affidavit/EBT Card Replacement Request

FORM NUMBER - 032-03-0388

PURPOSE OF FORM - This form will allow the local agency to assess the reason for a replacement of an EBT card or determine the value of food destroyed. Depending on the reason for the loss, the local agency may credit the card replacement fee back to the household's EBT account or provide additional SNAP benefits to cover the value of food destroyed.

USE OF FORM - The agency must provide the form to households that report the loss or destruction of the EBT card due to a reason for which the local agency may credit the card replacement fee. The agency must also provide the form to households that report a household disaster that resulted in the loss of food purchased with SNAP benefits.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The local agency must provide a copy of the completed form to the household and file a copy in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Local agency staff should complete the identifying case information at the top of the form. A household member or an authorized representative must complete or provide information for the bottom section regarding the replacement of the EBT card or food destroyed. A household member must sign and date the form.

### INTERNAL ACTION AND VAULT EBT CARD AUTHORIZATION

TO: \_\_\_\_\_ Vault Card Issuance Unit \_\_\_\_\_ EBT Administrative Terminal Personnel Date \_\_\_/\_\_\_/\_\_\_

FROM Eligibility Worker/Supervisor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

RE: Case Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

I.  Authorization for a Vault EBT Card  
Vault card reason: (1) \_\_\_ Timely processing (2) \_\_\_ Household emergency (3) \_\_\_ Agency determination

Case Name Social Security Number \_\_\_\_\_ Case Name Birth Date \_\_\_/\_\_\_/\_\_\_

Issue a vault card to Authorized Representative \_\_\_\_\_

Address of vault card recipient: \_\_\_\_\_

II.  Authorization for crediting the card replacement fee to the household's account

Reason:  Household disaster:  Lost in the mail  Household Violence  
 Improperly manufactured  Reapplication, no card  Cardholder name changed

III.  Administrative error – Debit account for \$ \_\_\_\_\_.

IV.  Reactivate dormant EBT account.

V.  Repay SNAP Claim of \$ \_\_\_\_\_ from  Active  Dormant/expunged account

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#### Issuance/Administrative Unit Use

I. EBT Vault Card Number: \_\_\_\_\_ Card destroyed on \_\_\_/\_\_\_/\_\_\_

Type of identification seen:

Driver's License  Rent/Utility Bill/Receipt  School ID Card  Work ID Card  
 Library Card  Social Security Card  Other \_\_\_\_\_

I acknowledge that I received my EBT card or that I received the card on behalf of another household. I understand that I need to select a Personal Identification Number to use my benefits.

\_\_\_\_\_  
Cardholder's Signature Date

Cardholder failed to pick up vault card  Card destroyed  Vault card not prepared

II. Replacement fee credited on \_\_\_/\_\_\_/\_\_\_.

III. EBT account debited for \$ \_\_\_\_\_ for an administrative error on \_\_\_/\_\_\_/\_\_\_.

IV. EBT account reactivated on \_\_\_/\_\_\_/\_\_\_.

V. Repaid \$ \_\_\_\_\_ to SNAP Claim on \_\_\_/\_\_\_/\_\_\_.

Completed by \_\_\_\_\_ Date \_\_\_\_\_  
Issuance/Administrative Worker



Internal Action and Vault EBT Card Authorization

FORM NUMBER - 032-03-0387

PURPOSE OF FORM - The Eligibility Unit will use this form to communicate with the Issuance or Administrative Unit in the local agency.

USE OF FORM - The EW must complete the top portion of the form to authorize the Issuance Unit to prepare and issue a vault card to an eligible household or authorized representative. The Eligibility Supervisor must complete the top portion of the form to authorize the Issuance or Administrative Supervisor, as designated by the agency, to credit the card replacement fee to a household's EBT account. The Issuance or Administrative Unit must complete the bottom portion of the form to document the action taken. The primary cardholder or authorized representative must also sign the form to acknowledge receipt of the vault card. The agency must use the internal action form to document repayment of a claim with funds in an EBT account or to debit an account for an administrative error.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The Eligibility Worker or Supervisor must retain a copy of the form and forward the remaining copies to the Issuance or Administrative Unit for completion. The Issuance or Administrative Unit must retain a copy of the fully completed form and return the second copy to the Eligibility Unit. Upon receipt of the form, the Eligibility Worker or Supervisor must file the copy in the case file. The initial copy completed only by the Eligibility Unit may be discarded.

INSTRUCTIONS FOR PREPARATION OF FORM - The EW or Supervisor must complete the identifying case and unit information. The EW or Supervisor must complete the appropriate section of the top portion of the form to explain or authorize actions, including Section I to note why a vault card is necessary. The EW must include the address of the person who will receive the vault card, either the primary cardholder or authorized representative, for entry in the EBT system. The EW may attach a copy of the AECASE or AECAS1 ADAPT screen, as appropriate, to avoid transcription errors.

The Eligibility Supervisor must complete Section II to authorize crediting the card replacement fee back to the household's EBT account. The Eligibility Supervisor must also complete Section III to debit benefits from an account that were erroneously deposited as a result of an administrative error.

The EW or Supervisor may authorize the reactivation of a dormant account by completing Section IV. The Primary Cardholder may also contact the Issuance or Administrative Worker directly to request the reactivation of the account. The EW or supervisor may also authorize deducting funds from an account to repay a claim by completing Section V.

The Issuance Unit must promptly act to prepare a vault card for a household upon receipt of the form completed by the Eligibility Unit. The Issuance Worker must obtain and record identity verification before releasing the vault card and secure the signature of the primary cardholder or authorized representative on the form.

The completed form must remain with a prepared vault card until the cardholder comes to the agency. The Issuance Unit must destroy the card after five business days if the cardholder does not receive it or make additional arrangements to receive the card. The Issuance Worker must note the date of the destruction of the card on the form. If the agency opts to wait until the cardholder comes to pick up the vault card before preparing the card, the Issuance Unit must notify the EW if the cardholder fails to obtain the card within five business days after the initial authorization by the certification unit.

The supervisor of the Issuance or Administrative Unit, as determined by the agency, must complete the section to credit the card replacement fee back to the household's EBT account.

The Issuance or Administrative Worker or Supervisor must sign and date the form.

COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF SOCIAL SERVICES  
EMPLOYMENT SERVICES PROGRAMS  
COMMUNICATION FORM- From EW to ESW

To \_\_\_\_\_, ESW  
From \_\_\_\_\_, EW  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reply Needed By \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Participant \_\_\_\_\_  
Case Name \_\_\_\_\_  
Case Number \_\_\_\_\_

Participant's Client ID # \_\_\_\_\_  
 SNAPET     TANF     TANF-UP

Reapplication for TANF - Previous Failure to Sign Agreement of Personal Responsibility. APR signed on \_\_\_\_/\_\_\_\_/\_\_\_\_ (APR attached). Effective Date of TANF approval: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Result of reevaluation of non-exempt/mandatory status: \_\_\_\_\_.

Volunteer no longer wishes to participate.

Non-exempt/mandatory individual now exempt. Reason: \_\_\_\_\_.

Individual may be unable to participate in ESP/SNAPET program because \_\_\_\_\_

Individual is not able to     Read English     Write English

Individual will enter/entered employment at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Scheduled # of Hours/week \_\_\_\_\_. Rate of pay \$ \_\_\_\_\_ per \_\_\_\_\_.  
Frequency of pay: \_\_\_\_\_. Date of First Pay: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Individual/household no longer eligible for SNAP. Case closed due to: (check one)

Sanction; ANPA sent

Employment/ benefit reduction/savings information provided below

Other: \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Individual removed from the SNAP household due to: (check one)

Sanction: ANPA sent     Other \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Effective with payment on \_\_\_\_/\_\_\_\_/\_\_\_\_, benefits will be reduced from \$ \_\_\_\_\_ to \$ \_\_\_\_\_.

Individual appealed sanction. Case remains open until appeal resolved. Pre-hearing conference scheduled for \_\_\_\_/\_\_\_\_/\_\_\_\_.

Sanction ended effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

Mandatory registrant has been added back to SNAP unit.

TANF case reopened.

24-Month Eligibility Termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Appeal prior to 24-Month Closure or  Appeal of Hardship Denial prior to 24-Month Closure. Appeal scheduled for: \_\_\_\_/\_\_\_\_/\_\_\_\_.  Client has requested that case remain open until appeal resolved.

VIEW Transitional Payment established effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

VIEW Transitional Payment ended effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

Reason: \_\_\_\_\_

Amount of SNAP allotment for the month of \_\_\_\_\_ was \$ \_\_\_\_\_.

New certification period from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

Other \_\_\_\_\_

COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF SOCIAL SERVICES  
EMPLOYMENT SERVICES PROGRAMS  
COMMUNICATION FORM- From ESW to EW

To \_\_\_\_\_, EW  
From \_\_\_\_\_, ESW  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reply Needed By \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Participant \_\_\_\_\_  
Case Name \_\_\_\_\_  
Case Number \_\_\_\_\_

Participant's Client ID # \_\_\_\_\_  
 SNAPET     TANF     TANF-UP

- Volunteer signed APR on \_\_\_\_/\_\_\_\_/\_\_\_\_. Please update AEGNFS screen and run ED/BC.
- Reevaluation of non-exempt/mandatory status is requested. Reason: \_\_\_\_\_.
- Volunteer no longer wishes to participate. Please update AEGNFS screen and run ED/BC.

- Individual will enter education or training activity on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Individual will be a participant in work experience. Please provide the SNAP amount for the month of \_\_\_\_\_.

- Individual will enter/entered employment on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Employer \_\_\_\_\_  
Scheduled # of Hours/week: \_\_\_\_\_. Rate of pay: \$ \_\_\_\_\_ per \_\_\_\_\_.  
Frequency of pay: \_\_\_\_\_. Date of First Pay: \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Please send verification of employment.

- Individual has failed to comply with program requirements of \_\_\_\_\_. Good cause does not exist.
- Notify ESW if aware of good cause reason.
- Sanction for (check appropriate answer)
  - 1 month and compliance     3 months and compliance     6 months and compliance
- Comparability exists.
- Please provide the dollar amount of SNAP reduction due to employment or sanction.
- Please notify when the sanctioned individual has been added back to SNAP unit.
- Please notify when suspended TANF case has been reinstated.

- VIEW Transitional Payment enrollment opened effective \_\_\_\_/\_\_\_\_/\_\_\_\_.
- VIEW Transitional Payment enrollment closed effective \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Reason: \_\_\_\_\_.

- Hardship denied on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Hardship granted from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Hardship terminated on \_\_\_\_/\_\_\_\_/\_\_\_\_.

- Other \_\_\_\_\_

10/09

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EMPLOYMENT SERVICES PROGRAMS COMMUNICATION FORM

FORM NUMBER - 032-02-0072

PURPOSE OF FORM - To exchange information about an employment services participant between the eligibility worker(EW) and the employment services worker (ESW).

USE OF FORM - Either the eligibility worker or the employment services may originate the form when circumstances change for the participant that require the exchange of information.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM – The form consists of an EW to ESW page and an ESW to EW page. When the form is sent, both pages should be provided. A copy of the entire form should be retained in both the TANF/SNAP and VIEW/SNAPET files.

INSTRUCTIONS FOR PREPARATION OF FORM

The name of the EW and the ESW, the date the form is sent, and the date the reply is needed must be entered in the upper right hand corner by the worker who originates the form.

Enter the identifying information for the case and participant.

The remainder of the form is completed when messages must be communicated between the eligibility staff and the employment services staff. The worker will check whichever block communicates the desired information, requests the desired information, or are applicable to the situation. If the worker needs to communicate information that is not listed on the form, check "Other" and enter the information.



**SNAP Sanction Notice for Non-Compliance with a Work Requirement**

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Case Number	
Locality	
Worker	Date

Name: \_\_\_\_\_

- Voluntarily quit a job without good cause.
- Voluntarily reduced work hours to less than 30 hours per week without good cause.
- Refused or failed to comply with the following employment program requirement:

**The following sanction will be applied in your SNAP case as a result of the action:**

- The person named above is disqualified and will not be eligible to receive SNAP benefits for the months of \_\_\_\_\_. However, if the person failed to comply with an employment program requirement, the person must comply with that requirement before being able to receive SNAP benefits again.
- Your household's SNAP benefit of \$ \_\_\_\_\_ will be changed to \$ \_\_\_\_\_ effective \_\_\_\_\_.
- Your entire household will not be eligible to receive SNAP benefits for the months of \_\_\_\_\_. However, if the person failed to comply with an employment program requirement, the person must comply with that requirement before your household will be able to receive SNAP benefits again.

The sanction indicated above may be lifted before the end of the sanction period if your household is otherwise eligible and the person named above leaves the household or becomes exempt from the requirement to register for work.

If you do not agree with the proposed action, you may write or call me at the address and phone number below and ask for a conference or, you may have a fair hearing on your case. At the hearing, you will have a chance to explain why you think we made a mistake, and a hearing officer will decide if you are right. To request a fair hearing, call or write me, or write:

**Virginia Department of Social Services  
 801 East Main Street  
 Richmond, Virginia 23219-2901  
 Attention: Hearing and Legal Services Manager**

You may also request a fair hearing by calling toll free 1-800-552-3431. Please see the back of this form for additional information about the appeals process.

You must request your fair hearing within 90 days. If you appeal the action on your case before \_\_\_\_\_ assistance may continue. However, if assistance is continued, you may have to repay benefits you receive during the appeal process if the hearing decision supports the agency action.

Eligibility Worker:	Agency Address	Agency Telephone
For free legal advice call: <b>1-866-534-5243</b>		

## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for food stamps. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901.
- Call me at the number listed on the front.
- Call 1-800-552-3431.

### When to Appeal

- Within the next 90 days.
- Within 10 days of the date on this form to get the SNAP benefits continued.\*

Note: You may have to repay benefits you receive during the appeal process if the hearing decision supports the agency action.

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal within 10 days of the SNAP conference date. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your SNAP benefits, you may continue to receive benefits until there is a hearing decision. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Questions or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

SNAP SANCTION NOTICE FOR NONCOMPLIANCE WITH A WORK REQUIREMENT

FORM NUMBER - 032-03-0174

PURPOSE OF FORM - To inform households of reductions or terminations in their SNAP benefits due to sanctions for failure to comply with Employment Program requirements. The agency must also send this notice to notify households or individuals of the disqualification penalty caused by quitting a job or reducing work without good cause.

USE OF FORM - The EW must complete this form after there is a decision to sanction an individual or household. NOTE: If there must be simultaneous sanctions in both TANF and SNAP for the household's failure to comply with a work requirement, the agency must complete a joint Advance Notice of Proposed Action (032-03-0018) instead of this form.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The original must be sent to the household. The copy must be retained in the SNAP case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM

The agency must send this form for all employment program sanction situations, and findings of voluntary quit or work reduction, except for simultaneous TANF and SNAP sanctions as noted above. The agency must send the form even if the certification period is expiring or the household had previously been notified of adverse action for some other reason on another form.

Enter the appropriate identifying information at the top of the form.

Enter the name of the person who did not comply, and the requirement with which he/she did not comply. Obtain information from the Employment Service Worker for violations related to work registration other than failure to complete the registration process.

Check the appropriate entry to indicate if the entire household or if only an individual is to be sanctioned. List the months of the sanction, the reduction in benefits and the effective date, as appropriate.

Enter the date by which an appeal may be requested in order to continue benefits at the original amount. Enter the day that is 11 days after the date of mailing.

Complete the information at the bottom of the form.



Commonwealth of Virginia  
 Department of Social Services  
 NOTICE OF INTENTIONAL PROGRAM VIOLATION

Name and Address	Case Name
	Case Number
	Locality <span style="float: right;">Date</span>

An investigation of your \_\_\_\_\_ Temporary Assistance for Needy Families (TANF) or your \_\_\_\_\_ Supplemental Nutrition Assistance Program (SNAP) case has recently been completed. We have reason to believe you intentionally violated a program rule because :

We have the following evidence to support our case against you:

We will request an Administrative Disqualification Hearing (ADH) to determine if you or another person in your household should be disqualified from TANF or SNAP benefits. Please tell me if you have a disability or limited ability to speak and understand English or if you need special arrangements made so you can attend or present your case at the hearing.

You or your representative may look at the evidence we have. Please call the number below to arrange a convenient time to come to the local social services department to see the evidence.

You have the right to an ADH before we take any action to disqualify you from receiving benefits. However, if you wish, you may waive your right to this hearing. If you sign the attached waiver, you will be disqualified from receiving benefits for the period shown below even if you do not admit the facts as presented.

Temporary Assistance for Needy Families (TANF)

\_\_\_\_\_ 6 months, 1st violation    \_\_\_\_\_ 12 months, 2nd violation    \_\_\_\_\_ permanently, 3rd violation

If you are not receiving TANF benefits now, you will be subject to the above disqualification penalty whenever you apply for TANF and are found eligible for TANF benefits again.

Supplemental Nutrition Assistance Program (SNAP)

\_\_\_\_\_ months, 1st violation    \_\_\_\_\_ months, 2nd violation    \_\_\_\_\_ permanently, 3rd violation

\_\_\_\_\_ Other (Specify)

If you do not sign the attached waiver, an Administrative Disqualification Hearing will be held. If the hearing finds that you committed an Intentional Program Violation, you will be disqualified for the same period of time as shown above.

Please note that neither signing the attached waiver nor holding the hearing will prevent the State or Federal government from prosecuting you for an Intentional Program Violation in a criminal or civil court action, or from collecting the overpayment. You have the right to remain silent about the allegations as anything said or signed by you could be used against you in a court of law.

Worker	Telephone	For Free Legal Advice Call 1-866-534-5243
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## **What is an Administrative Disqualification Hearing?**

An administrative disqualification hearing is a hearing held to decide if you or a member of your household intentionally violated Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) rules. This is called an “intentional program violation.” The local department of social services will request that the state conduct a hearing when there is evidence that a violation occurred.

## **What is an Intentional Program Violation?**

An “intentional program violation” is any of the following actions:

- Making a false or misleading statement to the local agency, either orally or in writing, to get SNAP or TANF benefits to which you are not entitled. Even if your SNAP or TANF application is denied, you can be found guilty.
- Hiding information or not telling all the facts in order to get SNAP or TANF benefits to which you are not entitled.
- Using SNAP benefits to buy non-food items such as alcohol, tobacco, or paper products.
- Using or having SNAP benefits you are not supposed to have.
- Trading or selling SNAP benefits or access devices.

## **Advance Notification of an Administrative Disqualification Hearing**

The hearing officer will provide the date, time, and place of the hearing. You will be told at least 30 days before the hearing date. If you ask the hearing officer at least 10 days before the hearing to delay the hearing, the hearing will be rescheduled. The hearing will not be delayed, however, for more than 30 days. You will be told in writing what the charges are against you. You will also receive a summary of the evidence against you. You will be told in writing how and where you can see the evidence.

## **What Happens at the Administrative Disqualification Hearing?**

The hearing officer will decide if you are guilty of an “intentional program violation.” The hearing officer will make the decision based upon the evidence presented at the hearing. At the hearing, you may:

- See all the documents and records being used at the hearing.
- Present the case or have a legal representative or someone else present the case.
- Bring witnesses.
- Question any testimony or evidence.
- Confront all witnesses and ask them questions.
- Present evidence to establish the household member’s side of the case.
- Remain silent about the charges.

NOTICE OF INTENTIONAL PROGRAM VIOLATION

FORM NUMBER - 032-03-0721

PURPOSE OF FORM - To advise a person that he/she is suspected of having committed an intentional program violation (IPV).

USE OF FORM – The worker must complete this form to advise a household that an IPV is suspected. The worker must send this form with the Waiver of Administrative Disqualification Hearing. The Administrative Disqualification Hearings pamphlet (b032-01-0961) may also be sent.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - Send the original to the individual suspected of committing an IPV and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Complete the form with appropriate information to note the program involved, the actions allegedly committed, the supporting evidence, and the length of the disqualification period. Sign the form and complete the information at the bottom of the form.



Commonwealth of Virginia  
 Department of Social Services  
 WAIVER OF ADMINISTRATIVE DISQUALIFICATION HEARING

Name and Address	Case Name	
	Case Number	
	Locality	Date

The Notice of Intentional Program Violation told you that we suspect you intentionally violated a program rule for  Temporary Assistance for Needy Families (TANF) or  Supplemental Nutrition Assistance Program (SNAP) benefits. The Notice listed the evidence against you.

The amount of benefits overpaid: \$ \_\_\_\_\_ TANF benefits \$ \_\_\_\_\_ SNAP benefits

This form is a WAIVER of an Administrative Disqualification Hearing (ADH).

IF YOU CHOOSE TO SIGN THIS WAIVER, you must indicate whether or not you admit the facts as presented in the Notice of Intentional Program Violation. Please note: You do not have to admit to any of the allegations.

If you choose to sign this waiver, please return it by \_\_\_\_\_ to avoid scheduling a hearing. Please return the form to:

Agency Name and Address		
Worker	Telephone	For Free Legal Advice Call 1-866-534-5243

WAIVER

Check one of the following statements:

- I admit to the facts as presented and understand that a disqualification penalty will be imposed and a reduction of benefits will occur if I sign this waiver.
- I do not admit that the facts presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty and reduction of benefits will result.

Signature	Date
IF YOU ARE NOT THE CASE NAME, THAT PERSON MUST ALSO SIGN THIS WAIVER.	
Signature of Case Name if Other Than You	Date

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## **What is an Administrative Disqualification Hearing?**

An administrative disqualification hearing is a hearing held to decide if you or a member of your household intentionally violated Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) rules. This is called an “intentional program violation.” The local department of social services will request that the state conduct a hearing when there is evidence that a violation occurred.

## **What is an Intentional Program Violation?**

An “intentional program violation” is any of the following actions:

- Making a false or misleading statement to the local agency, either orally or in writing, to get SNAP or TANF benefits to which you are not entitled. Even if your SNAP or TANF application is denied, you can be found guilty.
- Hiding information or not telling all the facts in order to get SNAP or TANF benefits to which you are not entitled.
- Using SNAP benefits to buy non-food items such as alcohol, tobacco, or paper products.
- Using or having SNAP benefits you are not supposed to have.
- Trading or selling SNAP benefits or access devices.

## **What are the Penalties for an Intentional Program Violation?**

If the hearing officer finds that you are guilty, you be disqualified from receiving SNAP or TANF benefits . The length of the disqualification for SNAP will be 12 months for the first offense; 24 months for the second offense; and permanently for the third offense. For TANF, the disqualification will be 6 months for the first offense; 12 months for the second offense; and permanently for the third offense.

In addition, if the hearing officer finds that you intentionally gave false information or hid information about identity or residence to get SNAP benefits in more than one locality at the same time, you will be disqualified for 10 years.

## **Advance Notification of an Administrative Disqualification Hearing**

The hearing officer will provide the date, time, and place of the hearing. You will be told at least 30 days before the hearing date. If you ask the hearing officer at least 10 days before the hearing to delay the hearing, the hearing will be rescheduled. The hearing will not be delayed, however, for more than 30 days. You will be told in writing what the charges are against you. You will also receive a summary of the evidence against you. You will be told in writing how and where you can see the evidence.

## **What Happens at the Administrative Disqualification Hearing?**

The hearing officer will decide if you are guilty of an “intentional program violation.” The hearing officer will make the decision based upon the evidence presented at the hearing. At the hearing, you may:

- See all the documents and records being used at the hearing.
- Present the case or have a legal representative or someone else present the case.
- Bring witnesses.
- Question any testimony or evidence.
- Confront all witnesses and ask them questions.
- Present evidence to establish the household member’s side of the case.
- Remain silent about the charges.

WAIVER OF ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-0722

PURPOSE OF FORM - To advise a household member suspected of having committed an intentional program violation (IPV) that the right to a hearing may be waived but the disqualification penalty will be imposed if the waiver is signed.

USE OF FORM – The local agency must complete the form and send it to determine if a waiver to the administrative disqualification hearing can be obtained before referring the case to the Hearing Authority. This form must be sent with the Notice of Intentional Program Violation.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency must send copies to the individual suspected of committing an IPV and to the Appeals and Fair Hearings Manager if the waiver is signed and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Enter the amount of the overpayment or overpayment for the program involved. Complete the form with the date by which the form must be returned if the waiver is to be activated. Enter a date that is 10 days after the mailing date.

If the individual waives the right to the hearing, the individual must complete the rest of the form and return it to the local agency.

If a signed waiver is returned to the agency, send a copy to the Appeals and Fair Hearings Manager.



Commonwealth of Virginia  
 Department of Social Services  
 REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

Case Name	Case Number	Locality
Address	<input type="checkbox"/> TANF Violation 1 2 3	<input type="checkbox"/> SNAP Violation 1 2 3
	IPV Period	IPV Period
	Overpayment Amount \$	Overpayment Amount \$

\_\_\_\_\_ is alleged to have committed the following act(s) of intentional program violation:

We have the following evidence to support our case:

Copies of evidence to be presented at the hearing to prove the allegation are attached, including: 1) Verification or documents to support the charge; 2) Any applications for Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program benefits signed by the accused during the time in which the intentional program violation allegedly occurred.

Information in this referral is provided with the knowledge it will be used in reaching a decision on the allegations made in this referral, and will be made available to the accused individual or representative.

Submitted by	Title	Telephone	Date
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REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-0725

PURPOSE OF FORM - To refer cases to the State Hearing Authority when an individual is suspected of having committed an intentional program violation (IPV).

USE OF FORM – The local agency worker must complete the form to provide information needed by the State Hearing Authority in order to initiate an administrative disqualification hearing. Mail the referral to:

Virginia Department of Social Services  
Hearings and Legal Services Manager  
801 East Main Street  
Richmond, VA 23219-2901

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency must send two copies to the Hearings Manager and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the information requested at the top of the form. The IPV Period is the span of time over which the IPV occurred. This will often coincide with the dates over which a claim was established.

The " Overpayment Amount" is the total amount of the claim that relates to the IPV. If the IPV was due to an act that did not result in an overpayment, indicate "0" overpayment in this block. This may include, for example, misrepresenting the household's income on an application that was subsequently denied.

Explain the intentional act alleged and the evidence the agency has to support its claim. Evidence listed here must be made available to the individual and will be presented at the hearing. Confidential or other information restricted from the household cannot be the basis of the evidence to support the accusation of an IPV.

The agency director or designee must sign the form.

Commonwealth of Virginia  
 Department of Social Services  
 ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

Name and Address	Case Name
	Case Number
	Locality

The local social service department has recently completed an investigation of your  Temporary Assistance to Needy Families (TANF) case, or  Supplemental Nutrition Assistance Program (SNAP) case.

The department believes you committed an intentional violation of a program rule because:

The department has the following evidence to support the case against you:

You or your representative may look at this evidence at the local social service department by calling your local worker to arrange a convenient time.

An Administrative Disqualification Hearing has been scheduled to examine the facts of your case. The hearing will be held at:

Time	Place
Date	

If it is found that you intentionally violated a program rule, you will be disqualified from receiving benefits for the period shown below.

TANF

\_\_\_ 6 months, 1st violation \_\_\_ 12 months, 2nd violation \_\_\_ permanently, 3rd violation

If you are not receiving TANF benefits now, you will be subject to this disqualification penalty whenever you apply for TANF and are found eligible for TANF benefits again.

SNAP

\_\_\_ months, 1st violation \_\_\_ months, 2nd violation \_\_\_ permanently, 3rd violation  
 \_\_\_ Other (Specify) \_\_\_\_\_

It is important that you or your representative be at the hearing. Otherwise a decision will be based solely on information provided by the local social service department. If you are unable to attend the scheduled hearing, you must contact the local social service department at least 10 days in advance of the hearing date to get the hearing rescheduled. If you or your representative fail to appear at a scheduled hearing, you must contact the local social service department within 10 days after the date of the hearing and present a good reason for not attending in order to receive a new hearing.

Hearing Officer	Phone Number	For Free Legal Advice Call 1-866-534-5243
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## **What is an Administrative Disqualification Hearing?**

An administrative disqualification hearing is a hearing held to decide if you or a member of your household intentionally violated Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) rules. This is called an “intentional program violation.” The local department of social services will request that the state conduct a hearing when there is evidence that a violation occurred.

Even though a hearing is scheduled, this does not prevent the State or Federal Government from prosecuting you for an intentional violation of a program rule in a court of law or from collecting the overpayment

## **What is an Intentional Program Violation?**

An “intentional program violation” is any of the following actions:

- Making a false or misleading statement to the local agency, either orally or in writing, to get SNAP or TANF benefits to which you are not entitled. Even if your SNAP or TANF application is denied, you can be found guilty.
- Hiding information or not telling all the facts in order to get SNAP or TANF benefits to which you are not entitled.
- Using SNAP benefits to buy non-food items such as alcohol, tobacco, or paper products.
- Using or having SNAP benefits you are not supposed to have.
- Trading or selling SNAP benefits or access devices.

## **What Happens at the Administrative Disqualification Hearing?**

The hearing officer will decide if you are guilty of an “intentional program violation.” The hearing officer will make the decision based upon the evidence presented at the hearing. At the hearing, you may:

- See all the documents and records being used at the hearing.
- Present the case or have a legal representative or someone else present the case.
- Bring witnesses.
- Question any testimony or evidence.
- Confront all witnesses and ask them questions.
- Present evidence to establish the household member’s side of the case.
- Remain silent about the charges.

## **Notification of Decision by Hearing Officer**

The hearing officer will make a decision on the case based on all the evidence presented. The hearing officer will tell you in writing what the decision is. You will receive this written decision within 90 days after the hearing date.

If the hearing officer decides that you are guilty of an intentional program violation, the local agency will send a notice to say:

- You will be disqualified from getting benefits;
- When you will be disqualified; and
- The amount of benefits the rest of the household will get.

## **Review of the Hearing Officer’s Decision**

If you are not satisfied with the hearing officer’s decision, you may seek a ruling from a court. You may also ask to have the decision reviewed but the review cannot change the decision.

ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-724

PURPOSE OF FORM - To schedule an administrative disqualification hearing (ADH).

USE OF FORM – The hearing officer must complete the form to provide an individual with a notice in advance of an ADH. The form must be sent by first class mail or certified mail with return receipt requested, or may be provided by any other reliable method. The ADH pamphlet may be sent to the individual with the advance notice or provided on request.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The hearing officer must send a copy to the individual alleged to have committed an IPV and to the local agency. The hearing officer must keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information at the top of the form. Information provided on the referral for the ADH will be used as the basis for the hearing.

Complete the form with the date, time and location of the hearing. Note the disqualification period for the IPV. Include other information as needed to complete the form.



Commonwealth of Virginia  
 Department of Social Services  
 ADMINISTRATIVE DISQUALIFICATION HEARING DECISION

Name and Address	Case Name
	Case Number
	Locality

On the basis of evidence presented at the Administrative Disqualification Hearing held on \_\_\_\_\_, it has been determined that you:

\_\_\_\_\_ DID NOT COMMIT an intentional violation of a Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) rule.

\_\_\_\_\_ DID COMMIT an intentional violation of a Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) rule.

If you did commit an intentional program violation, the local agency will disqualify you from receiving benefits for the time shown below:

TANF Benefits

\_\_\_\_\_ 6 months, 1st violation \_\_\_\_\_ 12 months, 2nd violation \_\_\_\_\_ permanently, 3rd violation

If you are not receiving TANF benefits now, the period of disqualification will be postponed until such time as you apply for TANF benefits and are found eligible again.

SNAP Benefits

\_\_\_\_\_ months, 1st violation \_\_\_\_\_ months, 2nd violation \_\_\_\_\_ permanently, 3rd violation  
 \_\_\_\_\_ Other (Specify)

The local agency will notify you of the date the disqualification will take effect. Also, the local agency will notify you of the effect the disqualification will have on the benefits to be received by any remaining household members.

This hearing decision does not prevent the local agency, State or Federal government from asking you to pay back the amount of any extra TANF or SNAP benefits your household was not eligible to receive. The local agency will send you a letter requesting repayment.

If you are not satisfied with the hearing decision, you may seek a ruling from a court. You may also ask for a review of this decision but this review cannot change the decision however. Send a written request within 10 days of receipt of this notice to:

Virginia Department of Social Services  
 Hearings and Legal Services Manager  
 801 East Main Street  
 Richmond, VA 23219-2901

Hearing Officer	Date
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ADMINISTRATIVE DISQUALIFICATION HEARING DECISION

FORM NUMBER - 032-03-0723

PURPOSE OF FORM - To advise the household member suspected of an intentional program violation (IPV) of the outcome of the Administrative Disqualification Hearing (ADH).

USE OF FORM – The hearing officer must complete the form to include the decision rendered.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The hearing officer must send the original to the household member and send a copy to the local agency. The hearing officer must keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information requested at the top of the form. Complete the form showing the date of the hearing and note whether an IPV was committed. If an IPV was determined, note the disqualification period for the program involved. The hearing officer must provide the written decision within 90 days of the date of the hearing.

Commonwealth of Virginia  
 Department of Social Services  
 NOTICE OF DISQUALIFICATION FOR INTENTIONAL PROGRAM VIOLATION

Name and Address	Case Name	
	Case Number	
	Locality	Date

This notice is to inform you of the disqualification of a person from the \_\_\_\_\_ Temporary Assistance for Needy Families (TANF) program, or \_\_\_\_\_ Supplemental Nutrition Assistance Program (SNAP).

\_\_\_\_\_ has been disqualified for the amount of time shown:

TANF \_\_\_\_\_ 6 months \_\_\_\_\_ 12 months \_\_\_\_\_ Permanently

SNAP \_\_\_\_\_ months \_\_\_\_\_ Permanently \_\_\_\_\_ Other (specify) \_\_\_\_\_

The reason for the disqualification is shown below:

\_\_\_\_\_ Court of appropriate jurisdiction found the person guilty of committing an intentional program violation of \_\_\_\_\_ TANF or \_\_\_\_\_ SNAP policy.

\_\_\_\_\_ An Administrative Disqualification Hearing found the person guilty of committing an intentional program violation of \_\_\_\_\_ TANF or \_\_\_\_\_ SNAP policy.

\_\_\_\_\_ The person waived his or her right to an Administrative Disqualification Hearing. The person had been informed that the disqualification penalty would be imposed.

The disqualification period will begin:

\_\_\_\_\_ From the TANF program, effective \_\_\_\_\_.

The TANF payment will change from \$ \_\_\_\_\_ to \$ \_\_\_\_\_.

\_\_\_\_\_ If this blank is checked, the disqualification will begin when the person next applies for and is found eligible for TANF.

\_\_\_\_\_ For SNAP benefits, effective \_\_\_\_\_.

The SNAP allotment will change from \$ \_\_\_\_\_ to \$ \_\_\_\_\_.

Worker	Telephone	For Free Legal Advice Call 1-866-534-5243
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NOTICE OF DISQUALIFICATION FOR INTENTIONAL PROGRAM VIOLATION

FORM NUMBER - 032-03-0052

PURPOSE OF FORM - To advise the household of a disqualification due to an intentional program violation.

USE OF FORM – The local agency worker must send this form to advise the household of the length, reason, effective date of a disqualification, and the benefit impact.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - Send the original to the household and keep a copy in the case record.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the form with information appropriate for the case and for the program involved. Enter the name of the individual who is to be disqualified.

**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF SOCIAL SERVICES  
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)  
MISSED INTERVIEW NOTICE**

TO:


Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ You missed the interview to discuss your SNAP application on \_\_\_\_\_. You must reschedule the interview before \_\_\_\_\_ or we will deny your application.

Please call \_\_\_\_\_ to schedule the interview.

\_\_\_\_\_  
Eligibility Worker

\_\_\_\_\_  
Telephone number

Missed Interview Notice

FORM NUMBER - 032-03-0419

PURPOSE OF FORM - To notify an applying household about missing an interview and the need to reschedule the interview.

USE OF FORM - The Eligibility Worker (EW) must complete the form after an applicant has missed a scheduled interview. The notice advises the applicant to reschedule the interview before the 30<sup>th</sup> day following the application filing date.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must mail the form to the household and retain a copy of the completed form.

INSTRUCTIONS FOR PREPARATION OF FORM - The worker must complete the identifying case information and note the date of the missed interview and the deadline for rescheduling the interview. The deadline will be the 30<sup>th</sup> day after the application date or the last business day before the 30<sup>th</sup> day if the 30<sup>th</sup> day falls on a weekend or holiday.

**NOTICE OF ACTION AND EXPIRATION**

This is to inform you of action taken on your SNAP application

[ \_\_\_\_\_ ]  
[ \_\_\_\_\_ ]

CASE NUMBER
DATE
COUNTY/CITY

**SECTION 1. ACTION ON APPLICATION DATED \_\_\_\_\_**

Approved for following months \_\_\_\_\_

Amount first month \$ \_\_\_\_\_ Months covered \_\_\_\_\_ Amount for following months \$ \_\_\_\_\_

You selected \_\_\_\_\_ as Head of Household. If all adult members do not agree, contact your worker within 10 days.

**YOU MUST REPORT WITHIN 10 DAYS REQUIRED CHANGES IN THE PERSON IN YOUR HOUSEHOLD AND IN YOUR FINANCIAL SITUATION.** If necessary, you may call collect.

If you do not agree with the action we have taken or the amount of SNAP benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake, and a hearing officer will decide if you are right. You may also request a fair hearing by calling toll free 1-800-552-3431. You must request your fair hearing within the next 90 days. If you appeal the action on your case before \_\_\_\_\_ assistance may continue. However, if assistance is continued, you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action. For additional information about appeals and fair hearings, please see the back of this notice.

**SECTION 2. ACTION REQUIRED TO RECEIVE UNINTERRUPTED BENEFITS**

Your SNAP certification period will end on \_\_\_\_\_

Your eligibility for SNAP benefits is expiring. For uninterrupted benefits, you must file a new application by \_\_\_\_\_ have an interview, and be found eligible based on the information you give. If you do not file an application by this date, there may be an interruption in your benefits.

We can only start the renewal process once you file an application. You or your authorized representative may file an application that has at least your name, address, and your signature.

- In person at the address shown above or below;
- By mail, fax, by e-mail; or
- Online at [www.vafood.org](http://www.vafood.org).

- in the office
- by telephone

You must have an interview. We have scheduled an appointment for an interview on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m. If this interview appointment is not convenient, please let us know immediately. If you miss this interview appointment, it will be your responsibility to reschedule it.

In addition to the application and interview, you must give us proof of your income, expenses, or other information to help us make a decision on your application. Please have your information available when you file the application or have your interview.

If a telephone interview is scheduled, you must:

- complete the enclosed application form;
- return the completed application by \_\_\_\_\_ to the address above or below;
- provide a telephone number where you can be reached during the scheduled time.

If everyone in your house receives Supplemental Security Income (SSI) or plan to apply for SSI, you may renew your eligibility for SNAP benefits at the Social Security Administration (SSA) office instead of filing you application at the local social services department. The Social Security office must also receive your application by the date indicated above.

Worker	Telephone Number	For Free Legal Advice Call <b>1-866-534-5243</b>
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## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901.
- Call me at the number listed on the front.
- Call 1-800-552-3431.

### When to Appeal

- Within the next 90 days.
- Within 10 days of the date on this form to get the SNAP benefits continued.\*

\* Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal within 10 days of the conference date for SNAP. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your SNAP benefits, you may continue to receive benefits until there is a hearing decision. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Questions or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

NOTICE OF ACTION AND EXPIRATION

FORM NUMBER - 032-03-0460

PURPOSE OF FORM - To notify applying households of the approval of the application and the end of the certification period so that households will have the opportunity to file a timely application for recertification.

USE OF FORM - To be sent by the local agency to advise the household of the approval of the application, the certification period, amount of benefits and the date by which a recertification application must be filed.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM – Mail or give a copy to the household. Retain a copy in the case record.

INSTRUCTIONS FOR PREPARATION - The form may be used in place of the Notice of Action and the Notice of Expiration. If used, the Notice of Action And Expiration must be completed by the eligibility worker and provided to the applicant upon the approval of the application. This form is appropriate only for those households assigned a one-month certification period or those approved in the last month of eligibility.



**ADAPT VERIFICATION FORM**

FIPS :

Case Name:	ADAPT Case #: Legacy Case #:	Residence Verification:
Programs:	Application/Renewal Date:	Identity Verification:
Authorized Representative/Identity Verification:		Interview Date: Face to Face Interview: <input type="checkbox"/> Yes <input type="checkbox"/> No Telephone Interview: <input type="checkbox"/> Yes <input type="checkbox"/> No

**1. Resources:**

**2. Vehicles:**

Per#	Type/Code	Verification	Per #	Identifier	Verification
DMV <input type="checkbox"/> Match <input type="checkbox"/> No Match Date _____					

**3. Earned Income/Unearned Income:**

Per#	Type/Code	Verification

VEC  Match  No Match Date \_\_\_\_\_ SOLQI/SVES  Match  No Match Date \_\_\_\_\_ APECS  Match  No Match Date \_\_\_\_\_

**4. Shelter Expenses:**

**5. Day Care/Medical/Support Expenses:**

Per#	Type	Verification	Per #	Type	Verification

UTILITY STANDARD  Y  N  1-3  4+ PHONE STANDARD  Y  N HOMELESS STANDARD  Y  N

REASON FOR ENTITLEMENT TO STANDARD

**6. Divisionary Assistance Program**

Documentation of Circumstances:	Amount/Type Emergency                      Verification
Remember: Enter Sanction Period (POI) in ADAPT	

**7. Other (Check any items that require verification and document your verification in the space below)**

<input type="checkbox"/> Deprivation <input type="checkbox"/> Living with Specified Relative <input type="checkbox"/> Immunizations <input type="checkbox"/> Truancy <input type="checkbox"/> Excluded Persons/Reason <input type="checkbox"/> SNAP Work Requirement Exemption <input type="checkbox"/> SNAPET/ESP VIEW Registration or Participation <input type="checkbox"/> Voluntary Quit <input type="checkbox"/> Sanction/Penalty <input type="checkbox"/> Resource/Income Transfer <input type="checkbox"/> Disability/Aged <input type="checkbox"/> Health Insurance <input type="checkbox"/> HIPP Medical Questionnaire <input type="checkbox"/> Medicaid Assignment of Rights (Indicate Person(s) Ineligible) <input type="checkbox"/> Pregnancy/Conception Date/ Estimated Due Date <input type="checkbox"/> Other Specify: _____	
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**8. Good Cause Claimed:**

<input type="checkbox"/> DCSE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> FAMIS  Dropped Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Documentation: _____
Good Cause: <input type="checkbox"/> Exists <input type="checkbox"/> Does Not Exist	

**IF ALL PROGRAMS APPLIED FOR ARE ON ADAPT, PLEASE GO TO PAGE 4.**

**Evaluation of Eligibility**

9. Programs:  Medicaid  GR  AG  SLH  TANF-EA  RRP  FAMIS

**10. Case Number**      **11. Retroactive Medicaid Determination:**

	Retroactive Period From:	to:
	Service in past 3 months: <input type="checkbox"/> Y	Date <input type="checkbox"/> N

**12. Institutional Status:**

<input type="checkbox"/> NF	<input type="checkbox"/> CBC	<input type="checkbox"/> ACR/AFC	Date Entered	ACR/AFC Rate
DMAS-96 <input type="checkbox"/> Y <input type="checkbox"/> N	SAR <input type="checkbox"/> Y <input type="checkbox"/> N	Community Spouse? <input type="checkbox"/> Y <input type="checkbox"/> N		

**13. Income:**

Type	Countable Y/N	Calculations/Comments:	Amount
INCOME LIMIT:			TOTAL COUNTABLE INCOME:

**14. Resources**

Type	Countable Y/N	Calculations/Comments:	Amount
RESOURCE LIMIT:			TOTAL COUNTABLE INCOME:

**15. Spend-down Calculation:**

Period	Person(s)	Countable Income	Income Limit	Excess Income

**16. Medicaid Covered Group:**

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**17. State/Local Hospitalization:**

Person(s)	Service Date(s)	Provider(s)	Applied within 30 days? Y/N

**18. General Relief Maintenance:**

Period of Unemployment:	Applied for SSI? <input type="checkbox"/> Y	Date:	<input type="checkbox"/> N
SSI Decision Appealed? <input type="checkbox"/> Y <input type="checkbox"/> N	Release of SSI Check Signed? <input type="checkbox"/> Y	Date:	<input type="checkbox"/> N
<input type="checkbox"/> Full Standard	<input type="checkbox"/> Modified Standard	Reason for Modified Standard:	

**19. Emergency Assistance:**

Date and Reason for Emergency:	
Assistance Previously Received: <input type="checkbox"/> Y <input type="checkbox"/> N	Dates and Amounts Received:

**20. Comments:**

**21. Disposition:** Date Given: SNAP Hotline Info      Benefit Programs Pamphlet      Medicaid Handbook

SNAP	TANF	Medicaid	FAMIS	TANF-EA/GR/AG//SLH/RRP
Certification Period:      to				

**22. Signatures:**

EW Signature	Date	Supervisor Signature	Date

**PARTIAL REVIEWS AND CHANGES**

Program	Action Date	Effective Date	Reason for review, methods and dates of verification	Worker's Signature and Date (Supervisor's Signature/Date)

ADAPT VERIFICATION FORM

FORM NUMBER - 032-03-0366

PURPOSE OF FORM – May be used to document methods and dates of verification of eligibility factors for SNAP and TANF cases. In addition, this form may be used to document verification and determine eligibility for Medicaid, General Relief, SLH, TANF-EA, Refugee Assistance, and Auxiliary Grants when the evaluation is being completed at the same time for TANF or SNAP benefits. When eligibility for other programs is being evaluated separately from SNAP or TANF, the Evaluation of Eligibility form (032-03-0823) may be completed. Documentation must be in sufficient detail to permit a supervisor, Quality Assurance, fraud investigator, or any other person reviewing the case record and information in ADAPT to determine the reasonableness and accuracy of the determination of eligibility.

USE OF FORM - The form may be completed at application and renewal for all programs for which the applicant/recipient is applying or receiving assistance. The form may also be used to document and verify interim changes and determine continued eligibility, as appropriate.

DISPOSITION OF FORM - The form must be retained in the case record with the appropriate application.

INSTRUCTIONS FOR PREPARATION OF FORM - When completing this form, it is not necessary to restate information if it is attached. Reference must be made to any information attached to the form.

CASE INFORMATION

Enter identifying case and application information, as appropriate.

- Residence Verification: Verify residence, as required by the program.
  - Identity Verification: Verify identity, as required by the program.
  - Authorized Representative/Identity Verification: Enter the authorized representative's name and verify identity, as required by the program.
  - Interview Date: Enter the date the applicant/recipient or authorized representative is interviewed. Indicate whether the interview was held in person or by telephone.
1. Resources: Verify and assess resources as required by the program. For each resource verified, enter the ADAPT person number, the type of resource or ADAPT resource code (e.g., bank accounts, real property, business or farming equipment) and verification (date, method, and source of verification).
  2. Vehicles: Complete vehicle information as required by the program. For each vehicle, enter the ADAPT person number, the vehicle identifier used in ADAPT, and verification (date, method, and source of verification). Complete a DMV inquiry and indicate whether a match was found, the date of the DMV records check, and attach the match. Document resolution of any discrepancies. If matches must be completed on more than

10/09

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one person, use the Comments section for the additional persons. If no change has occurred since the previous match, the agency may indicate "no change" and is not required to print the match information again.

3. Earned and Unearned Income: For each source of income verified, enter the ADAPT person number, the type of income or the ADAPT income code, and verification (date, method, and source of verification, and explanation as to the pay verification used, if applicable). Include in-kind income and vendor payments.

Indicate when APECS, VEC, or SOLQ-/SVES matches were checked, and attach any matches. Document resolution of any discrepancies. If matches must be completed on more than one person, use the Comments section for the additional persons. If no change has occurred since the previous match, the agency may indicate "no change" and is not required to print the match information again.

4. Shelter Expenses: Verify shelter expenses as required by the program. Enter the ADAPT person number, the type of expense, and the date, method and source of verification.
5. Day Care/Medical/Support Expenses: Verify these expenses as required by the program. For each expense verified, enter the ADAPT person number, the type (day care, medical expense, or support), and verification (date, method, and source of verification).
6. Diversionsary Assistance Program: Enter the date, method, and source of the verification received documenting the need(s) for diversionsary assistance, the type of emergency, and the amount needed to resolve the emergency.
7. Other Documentation: Check the appropriate items and enter the date, method, and source of verification. If "Other" is checked, specify the requirement being documented or questionable information being resolved, e.g., separate household status.
8. Good Cause Claimed: Check the type of good cause claim applicable to the program(s) evaluated. Indicate whether good cause exists and explain the basis for the decision.

**NOTE:** IF ALL PROGRAMS APPLIED FOR ARE ON ADAPT, PROCEED TO ITEMS 20 -22, AS APPLICABLE, otherwise complete #9-19.

9 -12 Complete as appropriate.

13. Income: Enter the type of income, whether it is countable, any calculations/explanations, and the amount of countable income from each source. Enter the appropriate income limit and the total countable income.
14. Resources: Enter the type of resource, whether it is countable, any calculations/explanations, and the amount of each countable resource. Enter the appropriate resource limit and the total countable resources.
15. Spend-down Calculation: Complete, as appropriate.

16. Medicaid Covered Group: Complete as appropriate. Specify the covered group from Volume XIII, Chapter M03. If the applicant/recipient does not meet a covered group, document the basis for the decision.
- 17.-19 Complete as appropriate.
20. Comments: Enter any additional information pertinent to the case not stated elsewhere, including calculations, such as Medicaid budget units.
21. Disposition: Enter the disposition for applicable programs. Enter the certification period for the SNAP case.
22. Signatures: The Eligibility Worker must sign and date the form. If a supervisory review is done, the supervisor must sign and date the form also.

PARTIAL REVIEWS AND CHANGES - Complete, as appropriate, for changes that occur between renewals to determine the effect on eligibility.



**NOTICE OF TRANSFER**


Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

Your \_\_\_\_\_ SNAP (Food Stamp), \_\_\_\_\_ Medicaid, or \_\_\_\_\_ Temporary Assistance for Needy Families (TANF) case(s) was transferred to \_\_\_\_\_ because of your recent move to that city or county.

**Your benefits for these programs will continue without interruption.**

Your TANF grant will change from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ because of your move to the new city/county.

\_\_\_\_\_ If the amount of your SNAP or TANF benefits went up because of a reported change in income, expenses, or the number of people in your household, you must show proof of the change. You will need to give this information to the new agency within 10 days or the amount of your SNAP or TANF benefits will go back to \$ \_\_\_\_\_ without additional notice.

You must report changes or file applications with the new agency. The address and telephone number of the new agency is:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

\_\_\_\_\_  
(Worker Signature)

\_\_\_\_\_  
(Telephone Number)

**REMINDER: Please keep your Virginia EBT Card, if you receive SNAP benefits, your EPPICard, if you receive TANF benefits, and your Medicaid card, if you receive Medicaid. You do not need a new card just because of your move.**

## APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a hearing on your case. You will have a chance to explain why you think we made a mistake at the hearing and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or SNAP benefits. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services (DMAS).

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

### How to File an Appeal

- Send a written request for Medicaid, FAMIS PLUS, or SLH appeals to Client Appeal Division, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.
- Send a written request for financial assistance and SNAP benefits appeals to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 801 East Main Street, Richmond, Virginia 23219-2901 or call me at the number listed on the front, or call 1-800-552-3431

### Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or SNAP benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for financial assistance benefits within two days following the date of the conference and within 10 days of the SNAP conference. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or SNAP benefits, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you receive during the appeal process if the hearing decision supports the agency action.

### Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearing officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearing officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request. You will get the hearing officer's decision within 90 days of the date the Department of Medical Assistance Services receives your appeal request for Medicaid, FAMIS PLUS, or SLH appeals.

## HIPAA PORTABILITY RIGHTS

Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. You may request a "Certificate of Creditable Coverage" for your coverage by visiting the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) or contacting the Helpline at 804-786-6145.

Notice of Transfer

FORM NUMBER - 032-03-0658

PURPOSE AND USE OF FORM - To advise a household that responsibility for a case has been transferred from one locality to another and to provide the contact information of the new agency.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The local agency worker must complete the form and mail it to the household when a case record is transferred to another locality.

INSTRUCTIONS FOR PREPARATION OF FORM –

Complete the form with identifying information of the case and with the telephone number and address of the local social services agency to which the case has been transferred. Mark the section to note if the household is required to provide verifications that affect the benefit amount to the new agency. Identify the information needed from the household on the Notice of Action or checklist and on the Case Record Transfer Form.



### CASE RECORD TRANSFER FORM

TO: DEPARTMENT OF SOCIAL SERVICES

FROM: DEPARTMENT OF SOCIAL SERVICES

\_\_\_\_\_  
COUNTY/CITY

\_\_\_\_\_  
COUNTY/CITY

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
ADDRESS

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#### I. TRANSFERRING LOCALITY CASE INFORMATION

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CASE NAME \_\_\_\_\_

CASE NUMBER \_\_\_\_\_

MOVED TO YOUR LOCALITY ON \_\_\_\_\_ AND IS RESIDING AT \_\_\_\_\_

UNIT MEMBERS \_\_\_\_\_

TYPE OF ASSISTANCE:

TANF VIEW CASE     TANF NON-VIEW CASE     REFUGEE CASH ASSISTANCE     OTHER \_\_\_\_\_

AMOUNT OF PAYMENT \_\_\_\_\_

LAST PAYMENT MONTH \_\_\_\_\_

VERIFICATION OF \_\_\_\_\_ NEEDED BEFORE ISSUANCE OF \_\_\_\_\_ BENEFITS

SNAP Benefits    CERTIFICATION PERIOD END DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

VERIFICATION OF \_\_\_\_\_ NEEDED BEFORE ISSUANCE OF \_\_\_\_\_ BENEFITS

PENDING MEDICAID     RECEIVING MEDICAID     RECEIVING REFUGEE MEDICAL ASSISTANCE

RECEIVING FAMIS (APPLICATION, EVALUATION, INCOME VERIFICATION, AND NOTICE OF ACTION ATTACHED)

ADDITIONAL REMARKS:

**SIGNATURE** (AGENCY REPRESENTATIVE) \_\_\_\_\_ **DATE:** \_\_\_\_\_

PRINTED NAME \_\_\_\_\_ **TITLE:** \_\_\_\_\_

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#### II. CONFIRMATION OF RECEIPT & DISPOSITION

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CASE RECORD WAS RECEIVED \_\_\_\_\_ DETERMINED:  ELIGIBLE     INELIGIBLE

EFFECTIVE \_\_\_\_\_  
DATE

FOR \_\_\_\_\_  
TYPES OF ASSISTANCE

ADDITIONAL REMARKS

**SIGNATURE** (AGENCY REPRESENTATIVE) \_\_\_\_\_ **DATE:** \_\_\_\_\_

PRINTED NAME \_\_\_\_\_ **TITLE:** \_\_\_\_\_

Case Record Transfer Form

FORM NUMBER - 032-03-0227

PURPOSE AND USE OF FORM - To communicate between local departments of social services when transferring responsibility for a case for program benefits from one agency to another. The form also serves as confirmation to acknowledge receipt of the case record.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency worker in the transferring agency must complete the names and addresses of the affected agencies and appropriate parts Section I of the form to address the types of assistance affected. The worker must prepare the case record for transfer to the new locality and send two copies of the form and case record to the receiving agency. The transferring agency must keep a copy of the completed form.

INSTRUCTIONS FOR PREPARATION OF FORM –

Complete the form with identifying information of the case and with the names and addresses of the agency from which the case is being transferred and the agency to which the case is being transferred. Complete Section I to identify the types of assistance and benefit amounts for the household. Add additional comments as needed. A representative of the transferring agency must sign the form.

A representative of the receiving local agency must complete Section II of the form to acknowledge the receipt of the case record. The agency must send copy of the completed form to the agency from which the case was transferred and keep a copy of the form.