

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

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

**A. HOUSEHOLD INFORMATION**

## 1. Your Contact Information

\_\_\_\_\_  
Your Name (last, first, middle initial)

\_\_\_\_\_  
Your Street Address (include apartment number)

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Your Mailing Address (if different from your street address)

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
In what city or county do you live?

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Primary Telephone Number

\_\_\_\_\_  
Alternate Telephone Number

**Primary Method of Correspondence**

If you would like to receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp ([www.CommonHelp.Virginia.gov](http://www.CommonHelp.Virginia.gov)), select one of the choices below. List either a cell telephone number or an email address. Once you choose a preferred electronic method of correspondence, it will be used for all programs on the case for which you have applied. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

If you are completing this application on behalf of another individual as an authorized representative, all correspondence to you will be mailed. The applicant may contact the local department of social services to learn how to change the method of correspondence.

Text    Email Cell Phone Number \_\_\_\_\_    Email Address \_\_\_\_\_

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

1

Self

\_\_\_\_\_  
Name (last, first, middle initial)

\_\_\_\_\_  
Relationship to You

\_\_\_\_\_  
Birth Date (mm-dd-yyyy)

\_\_\_\_\_  
Social Security Number:

\_\_\_\_\_  
City, State, Country of Birth:

Gender:       Male               Female

Are you a U.S. citizen?    Yes    No

Marital Status:    Married               Never Married

If No, immigration status: \_\_\_\_\_

Separated       Divorced       Widowed

US Residency Date: \_\_\_/\_\_\_/\_\_\_

Highest Grade Completed: \_\_\_\_\_

Alien Registration Number: \_\_\_\_\_

School Name if a Student: \_\_\_\_\_

Are you disabled or pregnant?    Yes    No

Are you a veteran or dependent?    Yes    No :

Are you temporarily living away from home?    Yes    No

Program(s) Requested:

Date Left \_\_\_/\_\_\_/\_\_\_    Expected Return Date \_\_\_/\_\_\_/\_\_\_

None    AG    SNAP    TANF

Reason for being away: \_\_\_\_\_

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

Ethnicity:       Hispanic/Latino       Not Hispanic/Latino

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

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

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

**Household Composition (continued)**

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

**2**

**Name** (last, first, middle initial) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Gender:**  Male  Female

**Marital Status:**  Married  Never Married

Separated  Divorced  Widowed

**Highest Grade Completed:** \_\_\_\_\_

**School Name if a Student:** \_\_\_\_\_

**Is this person a veteran or dependent?**  Yes  No :

**Program(s) Requested:**

None  AG  SNAP  TANF

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

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino

**Racial Heritage:**  White  Black/African American  Asian  Asian & Black/African American  Asian & White  
 American Indian/Alaskan Native  Black/African American & White  American Indian/Alaskan Native & White  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaskan Native & Black  Other/Unknown

**Relationship to Applicant** \_\_\_\_\_

**Birth Date** (mm-dd-yyyy) \_\_\_\_\_

**City, State, Country of Birth:** \_\_\_\_\_

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

If No, immigration status: \_\_\_\_\_

**US Residency Date:** \_\_/\_\_/\_\_

**Alien Registration Number:** \_\_\_\_\_

**Is this person disabled or pregnant?**  Yes  No

**Is this person temporarily away from home?**  Yes  No

**Date Left** \_\_/\_\_/\_\_ **Expected Return Date** \_\_/\_\_/\_\_

**Reason for being away:** \_\_\_\_\_

**3**

**Name** (last, first, middle initial) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Gender:**  Male  Female

**Marital Status:**  Married  Never Married

Separated  Divorced  Widowed

**Highest Grade Completed:** \_\_\_\_\_

**School Name if a Student:** \_\_\_\_\_

**Is this person a veteran or dependent?**  Yes  No :

**Program(s) Requested:**

None  AG  SNAP  TANF

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

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino

**Racial Heritage:**  White  Black/African American  Asian  Asian & Black/African American  Asian & White  
 American Indian/Alaskan Native  Black/African American & White  American Indian/Alaskan Native & White  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaskan Native & Black  Other/Unknown

**Relationship to Applicant** \_\_\_\_\_

**Birth Date** (mm-dd-yyyy) \_\_\_\_\_

**City, State, Country of Birth:** \_\_\_\_\_

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

If No, immigration status: \_\_\_\_\_

**US Residency Date:** \_\_/\_\_/\_\_

**Alien Registration Number:** \_\_\_\_\_

**Is this person disabled or pregnant?**  Yes  No

**Is this person temporarily away from home?**  Yes  No

**Date Left** \_\_/\_\_/\_\_ **Expected Return Date** \_\_/\_\_/\_\_

**Reason for being away:** \_\_\_\_\_

**4**

**Name** (last, first, middle initial) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Gender:**  Male  Female

**Marital Status:**  Married  Never Married

Separated  Divorced  Widowed

**Highest Grade Completed:** \_\_\_\_\_

**School Name if a Student:** \_\_\_\_\_

**Is this person a veteran or dependent?**  Yes  No :

**Program(s) Requested:**

None  AG  SNAP  TANF

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

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino

**Racial Heritage:**  White  Black/African American  Asian  Asian & Black/African American  Asian & White  
 American Indian/Alaskan Native  Black/African American & White  American Indian/Alaskan Native & White  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaskan Native & Black  Other/Unknown

**Relationship to Applicant** \_\_\_\_\_

**Birth Date** (mm-dd-yyyy) \_\_\_\_\_

**City, State, Country of Birth:** \_\_\_\_\_

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

If No, immigration status: \_\_\_\_\_

**US Residency Date:** \_\_/\_\_/\_\_

**Alien Registration Number:** \_\_\_\_\_

**Is this person disabled or pregnant?**  Yes  No

**Is this person temporarily away from home?**  Yes  No

**Date Left** \_\_/\_\_/\_\_ **Expected Return Date** \_\_/\_\_/\_\_

**Reason for being away:** \_\_\_\_\_

**Household Composition (continued)**

**5**

**Name** (last, first, middle initial) \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_  
**Gender:**  Male  Female  
**Marital Status:**  Married  Never Married  
 Separated  Divorced  Widowed  
**Highest Grade Completed:** \_\_\_\_\_  
**School Name if a Student:** \_\_\_\_\_  
**Is this person a veteran or dependent?**  Yes  No :  
**Program(s) Requested:**  
 None  AG  SNAP  TANF

**Relationship to Applicant** \_\_\_\_\_ **Birth Date** (mm-dd-yyyy) \_\_\_\_\_  
**City, State, Country of Birth:** \_\_\_\_\_  
**Is this person a U.S. citizen?**  Yes  No  
If No, immigration status: \_\_\_\_\_  
**US Residency Date:** \_\_/\_\_/\_\_\_\_  
**Alien Registration Number:** \_\_\_\_\_  
**Is this person disabled or pregnant?**  Yes  No  
**Is this person temporarily away from home?**  Yes  No  
**Date Left** \_\_/\_\_/\_\_\_\_ **Expected Return Date** \_\_/\_\_/\_\_\_\_  
**Reason for being away:** \_\_\_\_\_

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

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino  
**Racial Heritage:**  White  Black/African American  Asian  Asian & Black/African American  Asian & White  
 American Indian/Alaskan Native  Black/African American & White  American Indian/Alaskan Native & White  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaskan Native & Black  Other/Unknown

**6**

**Name** (last, first, middle initial) \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_  
**Gender:**  Male  Female  
**Marital Status:**  Married  Never Married  
 Separated  Divorced  Widowed  
**Highest Grade Completed:** \_\_\_\_\_  
**School Name if a Student:** \_\_\_\_\_  
**Is this person a veteran or dependent?**  Yes  No :  
**Program(s) Requested:**  
 None  AG  SNAP  TANF

**Relationship to Applicant** \_\_\_\_\_ **Birth Date** (mm-dd-yyyy) \_\_\_\_\_  
**City, State, Country of Birth:** \_\_\_\_\_  
**Is this person a U.S. citizen?**  Yes  No  
If No, immigration status: \_\_\_\_\_  
**US Residency Date:** \_\_/\_\_/\_\_\_\_  
**Alien Registration Number:** \_\_\_\_\_  
**Is this person disabled or pregnant?**  Yes  No  
**Is this person temporarily away from home?**  Yes  No  
**Date Left** \_\_/\_\_/\_\_\_\_ **Expected Return Date** \_\_/\_\_/\_\_\_\_  
**Reason for being away:** \_\_\_\_\_

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

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino  
**Racial Heritage:**  White  Black/African American  Asian  Asian & Black/African American  Asian & White  
 American Indian/Alaskan Native  Black/African American & White  American Indian/Alaskan Native & White  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaskan Native & Black  Other/Unknown

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

**B. RESOURCES**

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

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

- |                          |                                                              |                          |                                                        |                          |                                              |
|--------------------------|--------------------------------------------------------------|--------------------------|--------------------------------------------------------|--------------------------|----------------------------------------------|
| <b>Yes</b>               | <b>No</b>                                                    | <b>Yes</b>               | <b>No</b>                                              | <b>Yes</b>               | <b>No</b>                                    |
| <input type="checkbox"/> | <input type="checkbox"/> Cash \$_____                        | <input type="checkbox"/> | <input type="checkbox"/> Checking, Savings             | <input type="checkbox"/> | <input type="checkbox"/> Credit Union        |
| <input type="checkbox"/> | <input type="checkbox"/> 401K, 403B, etc.                    | <input type="checkbox"/> | <input type="checkbox"/> Promissory notes              | <input type="checkbox"/> | <input type="checkbox"/> Money Market Funds  |
| <input type="checkbox"/> | <input type="checkbox"/> Individual Retirement Account (IRA) | <input type="checkbox"/> | <input type="checkbox"/> Christmas Club                | <input type="checkbox"/> | <input type="checkbox"/> Deeds of Trust      |
| <input type="checkbox"/> | <input type="checkbox"/> Deferred Compensation Plan          | <input type="checkbox"/> | <input type="checkbox"/> Uniform Gift to Minor Account | <input type="checkbox"/> | <input type="checkbox"/> Retirement accounts |
| <input type="checkbox"/> | <input type="checkbox"/> Keogh Plan                          | <input type="checkbox"/> | <input type="checkbox"/> Certificate of Deposit (CD)   | <input type="checkbox"/> | <input type="checkbox"/> Trust funds         |
| <input type="checkbox"/> | <input type="checkbox"/> Stocks or bonds                     | <input type="checkbox"/> | <input type="checkbox"/> Pension plans                 | <input type="checkbox"/> | <input type="checkbox"/> Other               |

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

**a.**

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

**b.**

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

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

Note: Additional Resource information may be needed section if you are applying for the Auxiliary Grant program.

**C. INCOME**

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

- |                          |                                                     |                          |                                                          |                          |                                                       |
|--------------------------|-----------------------------------------------------|--------------------------|----------------------------------------------------------|--------------------------|-------------------------------------------------------|
| <b>Yes</b>               | <b>No</b>                                           | <b>Yes</b>               | <b>No</b>                                                | <b>Yes</b>               | <b>No</b>                                             |
| <input type="checkbox"/> | <input type="checkbox"/> Wages/Salary               | <input type="checkbox"/> | <input type="checkbox"/> Earned Sick Pay                 | <input type="checkbox"/> | <input type="checkbox"/> Self-employment              |
| <input type="checkbox"/> | <input type="checkbox"/> Contract Income            | <input type="checkbox"/> | <input type="checkbox"/> Babysitting/Adult or child care | <input type="checkbox"/> | <input type="checkbox"/> Any other money from working |
| <input type="checkbox"/> | <input type="checkbox"/> Vacation Pay               | <input type="checkbox"/> | <input type="checkbox"/> Farming/Fishing                 |                          |                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> Commissions, Bonuses, Tips | <input type="checkbox"/> | <input type="checkbox"/> Odd jobs                        |                          |                                                       |

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

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



**E. SNAP BENEFITS**

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

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

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

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

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

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

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

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

6a How do you heat your home? \_\_\_\_\_

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

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

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

\_\_\_\_\_

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

**USDA Nondiscrimination Statement**

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: [http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

**Commonwealth of Virginia Voter Registration Agency Certification**

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

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

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

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

\_\_\_\_\_  
Applicant Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*for agency use only*

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

\_\_\_\_\_  
Agency Staff Signature

\_\_\_\_\_  
Date

**VERIFICATION AND USE OF INFORMATION**

**Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:**

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System (IEVS)\*

\* Information received through IEVS will be requested, used and may be verified through collateral contacts when discrepancies are found. The information may affect the amount of benefits and/or your continued receipt of benefits.

**SNAP CHANGE REPORTING,**

You must report changes that occur for SNAP but, what you must report is tied to how long you are determined eligible for benefits, the certification period. You must report changes that occur during the certification period within 10 days, but no later than the 10th day of the month after the change occurs.

Changes that need to be reported during the certification period for SNAP depend on the length of the certification period. "Simplified Reporting" applies to households that are eligible for SNAP benefits for five (5) months or longer. "Change Reporting" applies to households that are eligible for one (1) month to four (4) months.

**INTERIM REPORT FILING**

In addition to reporting changes when they occur during the SNAP certification period, Simplified Reporting households may be required to submit an Interim Report in the sixth or twelfth month. The Interim Report is used to determine the amount of SNAP benefits households will receive for the second half of the certification period. The Interim Report provides a snapshot of household circumstances that were presented at the time of application. We will ask for proof of income changes and changes in legal obligations to pay child support. If households fail to return the completed Interim Report by the fifth of the month, SNAP benefits for the seventh or thirteenth month may be delayed or closed. Assistance for filing the Interim Report is available by calling the telephone number printed on the form.

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

I understand:

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

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

I filled in this application myself:  Yes  No  
If NO, it was read back to me when complete:  Yes  No

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

\_\_\_\_\_  
Witness to Mark or Interpreter \_\_\_\_\_ Date

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

\_\_\_\_\_  
Name of person completing application \_\_\_\_\_ Date \_\_\_\_\_ Relationship to applicant

Primary Telephone Number \_\_\_\_\_ Alternate Telephone Number \_\_\_\_\_