PART XXIV FORMS

PART XXIV FORMS (continued)

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

Return your completed application to:
_____ County/City DSS
_____
_____

GENERAL INFORMATION

With this application, you may apply for one or more of the following assistance programs:

- Auxiliary Grants (AG)
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- General Relief – Unattached Child (GR)
- Refugee Cash Assistance (RCA)
- TANF Diversionary Assistance (TANF DA)
- TANF Emergency Assistance (TANF EA)

Note that an application for TANF will be treated as an application for SNAP. Be sure to mark **TANF-No SNAP** in the **Household Composition** section if you only want to apply for TANF.

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 there are more than 6 people living in your home and you need more space to list everyone, tell the agency you need extra pages. If you have a disability or have difficulty with English, you may receive extra help to make sure you get the assistance or services you are eligible to receive.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you do not give needed information, we may not be able to determine your eligibility for assistance. 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.

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.

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)

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:

- determine the correctness, accuracy, and truthfulness of the application;
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

Your information may also be used or disclosed to study public benefit programs, such as SNAP or TANF.

Information regarding your race and ethnicity is not required and will not affect your eligibility or benefit amount. This information is requested to be sure that program benefits are provided without regard to race, color, or national origin.

NONDISCRIMINATION STATEMENT

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), 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. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who 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.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, 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**: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax**: (833) 256-1665 or (202) 690-7442; or
3. **phone**: (833) 620-1071; or
4. **email**: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding 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: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Do not write in shaded areas. These areas are for agency use only.

2. Complete **SECTION A: APPLICANT INFORMATION.** Complete the grid in **SECTION B: Household Composition** 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 C: INCOME** for everyone for whom you are applying. In addition, if you are applying for **TANF,** also provide income information for children age 18 or under, even if you are not applying for that child, and for the stepparent of the children for whom you are applying.

4. Answer the questions in **SECTION D: RESOURCES** for everyone for whom you are applying unless you are applying only for TANF.

5. After completing Sections A through D, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

TANF	**Section E,** page 5	**TANF Diversionary/Emergency Assistance**	**Section F,** page 6
SNAP	**Section G,** page 6	**Auxiliary Grants**	**Section H,** pages 7-8

6. Complete **SECTION I** for all programs if you want to have an Authorized Representative act on your behalf.

7. Read **CHANGE REPORTING AND PENALTIES** on pages 9-10.

8. Read and complete the last page of this application. Be sure to sign and date the application.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible. To qualify for Expedited Service: 1) your gross monthly income must be less than $150 and liquid resources $100 or less; 2) your monthly shelter bills must be higher than your household's gross monthly income plus your liquid resources; or 3) someone in your household must be a migrant or seasonal farm worker with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

_____ Telephone Number: _____

_____ _____

Signature: Date

Total income received/expected this month before deductions $_____

Total cash, money in checking/savings accounts, CDs, etc. $_____

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**

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) ❑ Yes ❑ No

_____ _____

Agency Staff Signature Date:

AGENCY USE ONLY		
CASE NAME		
CASE NUMBER		
LOCALITY	**SCREENER**	**DATE**

EXPEDITED SERVICE DETERMINATION

Income < $150 + resources ≤ $100 ❑ **YES** ❑ **NO**

Income + resources < shelter bills ❑ **YES** ❑ **NO**

For migrant or seasonal farm workers:

Resources ≤ $100 and ≤ $25 is expected in next 10 days from new income; ❑ **YES** ❑ **NO**

OR

Resources ≤ $100 and $0 income is expected from a terminated source for the rest of this month or next month. ❑ **YES** ❑ **NO**

EXPEDITE IF YES TO ANY OF THE ABOVE.

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

Return your completed application to:
_____ County/City DSS
_____
_____

A. APPLICANT INFORMATION
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? | **Email Address**

Primary Telephone Number | **Alternate Telephone Number**

What is the primary language spoken in your household?

❑ English ❑ Vietnamese ❑ Laotian ❑ Somali ❑ French ❑ Other (specify):
❑ Spanish ❑ Farsi ❑ Chinese ❑ Kurdish ❑ German _____
❑ Cambodian ❑ Haitian-Creole ❑ Korean ❑ Arabic ❑ Japanese

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), 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** _____

❑ YES ❑ NO 1. 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), TANF, Medicaid, General Relief, Auxiliary Grant, Foster Care, Adoption Assistance, or Refugee Cash Assistance? If **YES,** enter the information below.
Name:_____ Type of Benefit Received:_____
When:_____ From What County, City, or State:_____

❑ YES ❑ NO 2. 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._____

❑ YES ❑ NO 3. Have you or anyone for whom you are applying ever been disqualified from participating in TANF, SNAP, or Medicaid? If **YES**, give date and place of all disqualifications._____

❑ YES ❑ NO 4. 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 _____

❑ YES ❑ NO 5. Have you or anyone for whom you are applying ever been convicted of a felony as an adult on or after February 8, 2014 for the following:
a. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
b. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
c. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
d. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, who? _____.
If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

B. 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. List yourself first.

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 ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

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

2

Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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

3

Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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.

4

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

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

5

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**

❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP

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

C. INCOME

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

Yes	No		Yes	No		Yes	No	
❑	❑	Wages/Salary	❑	❑	Earned Sick Pay	❑	❑	Domestic Work
❑	❑	Contract Income	❑	❑	Babysitting/Adult or child care	❑	❑	Self-employment
❑	❑	Vacation Pay	❑	❑	Farming/Fishing	❑	❑	Any other money from working
❑	❑	Commissions, Bonuses, Tips	❑	❑	Odd jobs			

a.

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule** ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm-dd-yyyy)

b.

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule** ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm-dd-yyyy)

❑ 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 in the last 60 days? If **YES**, give name and explain: _____

_____

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

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

a. **Name of Person** | $ **Amount** | **Type of Money or Help** | **How Often Received?**

b. **Name of Person** | $ **Amount** | **Type of Money or Help** | **How Often Received?**

c. **Name of Person** | $ **Amount** | **Type of Money or Help** | **How Often Received?**

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

_____

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

_____

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

_____

D. RESOURCES

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

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

Yes	No		Yes	No		Yes	No	
❑	❑	Cash $_____	❑	❑	Checking, Savings	❑	❑	Credit Union
❑	❑	401K, 403B, etc	❑	❑	Promissory notes	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Deeds of Trust
❑	❑	Deferred Compensation Plan	❑	❑	Uniform Gift to Minor Account	❑	❑	Retirement accounts
❑	❑	Keogh Plan	❑	❑	Certificate of Deposit (CD)	❑	❑	Trust funds
❑	❑	Stocks or bonds	❑	❑	Pension plans	❑	❑	ABLE Account
❑	❑	Other _____						

— If **Yes to any of the above**, please provide the following information:

a.

Owner Name (last, first, middle initial) **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution **Account Type** **Account Number** **$ Balance**

Address of Bank or Institution

b.

Owner Name (last, first, middle initial) **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution **Account Type** **Account Number** **$ Balance**

Address of Bank or Institution

❑ YES ❑ NO 2. Has anyone received or expect to receive winnings of $3,500 or more from lottery or gambling? If **YES**, explain: _____

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

E. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) **(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)**

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. **You must identify both parents in order to receive TANF. If you intentionally misidentify a parent, you shall be prosecuted**	**2. IMMUNIZATION** (Answer **only if applying for TANF.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **Yes** Or **No** Or **Unknown**
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. TANF DIVERSIONARY ASSISTANCE/EMERGENCY ASSISTANCE

❑ YES ❑ NO 1. Does your household have an emergency need related to basic needs (food, shelter, shelter items, potential eviction, medical expenses, childcare expenses or the costs associated with getting or keeping employment including transportations costs)? If **YES**, give date and explain below.

❑ YES ❑ NO 2. Does anyone have emergency needs that result from a natural disaster or fire such as replacement of clothing, or the repair or replacement of household equipment and supplies which were destroyed? If **YES**, explain below.

❑ YES ❑ NO 3. Has your household experienced a loss or reduction of income (except TANF/Refugee Cash Assistance) in the six months prior to the date of application?

❑ YES ❑ NO 4. Does your household have a delay in starting to receive income resulting in the current emergency? (The income must start within 60 days following the application date.) If **YES**, who? _____

Date, description, and cause of emergency:

G. SNAP BENEFITS

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

❑ YES ❑ NO 2. 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 3. Is anyone living in your home renting a room from you (a roomer) or being provided a room and food (a boarder)? If **YES**, list names: _____

❑ YES ❑ NO 4. 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 5. 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? _____

H. AUXILIARY GRANTS (AG)

❑ YES ❑ NO 1 Do you live in an Assisted Living Facility, an Adult Foster Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____
City/County and State where you lived before entering the institution _____.
If outside Virginia, was placement made by a government agency? ❑ YES ❑ NO

❑ YES ❑ NO 2 Have you applied for or are you applying for supportive housing?

❑ YES ❑ NO 3 Do you have a spouse who does not live in the home? If **YES**, enter the Spouse's Name and address
_____

❑ YES ❑ NO 4. Have you lived in Virginia for the past 90 days?

❑ YES ❑ NO 5 Do you owe or did you pay any bills you had in the month of entry into an assisted living facility or adult foster care?

❑ YES ❑ NO 6. Do you have any unpaid medical bills for the three months before the application month?

Description of Bills	Dates of Bills	Dates Bills Paid

❑ YES ❑ NO 7. Do you own any household goods or personal effects worth more than $500, such as silver, fine china, furs, artwork, jewelry, or other items held for their value or as an investment?

Description and Value of Items

❑ YES ❑ NO 8. Do you have any burial plots, burial arrangements or trust funds for burial?

Owner(s)	Number of Plots Type of Arrangement:	Where	Value $ Amount Owed $	Date Acquired
Qwner(s)	Burial contract/agreement type: ❑ Irrevocable ❑ Revocable	Trustee/Authority/Funeral Home:	Funds Required $	Amount Paid $
Other information:				

❑ YES ❑ NO 9. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	Is this property used in your business or trade, including farming? YES ( ) NO ( )	Value	Amount Owed	Date Acquired

❑ YES ❑ NO 10. 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

❑ YES ❑ NO 11. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type, Make, Model, Year	Currently Licensed?	Vehicle ID# License #	Value Amount Owed	How Used	Date Acquired
		❑ YES ❑ NO	# #	$ $		

H. AUXILIARY GRANTS (AG) (continued)

❑ YES ❑ NO 12. Does anyone have any life insurance? If **YES,** provide information about each policy. List each policy separately. Attach a separate sheet if necessary.

Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			

An application for AG is also an application for Medicaid. The following questions will help determine Medicaid eligibilty through the Department of Social Services or possible eligibility for Advanced Premium Tax Credits (APTC) for private health insurance through the Federal Marketplace (Healthcare.gov).

❑ YES ❑ NO 13. Does anyone have health insurance? If **Yes**, complete the following:

Policy Holder:	Person(s) Insured:
Company Name, Address, Phone:	
Coverage Type:	Begin Date: / / End Date: : / /
ID Number:	Premium Amount: $

❑ YES ❑ NO 14. Does anyone have Medicare?

Person Insured	Claim Number	Coverage
		❑ Part A ❑ Part B
		❑ Part A ❑ Part B

15. List the names of everyone expected to be included on the same tax return as you for this year, whether or not they live in the same home as you. For anyone in the home that does not file taxes and does not expect to be on anyone else's tax return, list those names under "Non-filer(s)".

Tax Filer:	
Joint Taxpayer:	
Tax Dependent(s):	
Non-filer(s):	

I. Authorized Representative

An authorized representative may apply for benefits on your behalf or receive copies of your program notices. Your representative may also receive and use your SNAP benefits on your behalf. 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. Note that you may have only one representative who can access your benefits.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for benefits ❑ Receive correspondence ❑ Access or use SNAP benefits
	❑ Apply for benefits ❑ Receive correspondence ❑ Access or use SNAP benefits

CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

REPORTING CHANGES

You must report changes that occur. What you need to report and when you need to report it varies by each program as listed below or on the next page for SNAP.

TANF/Refugee Cash Assistance: Report within 10 days, but no later than the 10th day of the month after a change occurs. Report these changes:

- Your household income goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.
- Your address changes.
- An eligible individual leaves or enters the home.
- Changes that may affect your participation in VIEW such as, changes in income, employment, education, training, transportation, and child care.

General Relief-Unattached Child: Report the day the change occurs or the first day that the agency is open after the change occurs. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are other changes that may affect eligibility.

Auxiliary Grants: Report changes within 10 days. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are changes in your resources, including transferring assets/property or in any motor vehicles owned.

PENALTIES FOR TANF AND REFUGEE CASH ASSISTANCE (RCA) VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or RCA, 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 or RCA for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd 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.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

SNAP CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

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 you need to report during the certification period for SNAP will 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. Changes that need to be reported for each category are listed below.

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.

REPORTING REQUIREMENTS – SIMPLIFIED REPORTING HOUSEHOLDS

Certified five months or longer, households must report:

- The number of work hours goes under 20 per week for anyone between the ages of 18-49 if there are no children in your SNAP household;
- You have lottery or gambling winnings of $4,250 or more; or
- All the income for your household, before taxes, goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.

REPORTING REQUIREMENTS – CHANGE REPORTING HOUSEHOLDS

Certified four months or less), households must report:

- There is a change in the number of people in your household;
- Your address changes, including shelter expenses that change resulting from the move;
- The obligation to pay child support changes or the amount paid to someone outside the household changes;
- Your liquid resources, such as bank accounts, cash, bonds, etc. are $2,750 or $4,250 or more;
- You have lottery or gambling winnings of $4,250 or more;
- The number of work hours goes under 20 per week for anyone between the ages of 18-50 if there are no children in the home; or
- There are changes in income:
  - There are income changes of more than $125 except, you do not have to tell us if your TANF income changes if your TANF case is in Virginia;
  - The source of your income changes, including if you start or stop a job; or
  - Your job switches from full-time to part-time or part-time to full-time.

SNAP RESPONSIBILITIES AND PENALTIES FOR VIOLATIONS

You must not:

- **give false information or hide information to get SNAP benefits;**
- **trade or sell EBT cards or attempt to trade or sell EBT cards;**
- **use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products;**
- **use someone else's EBT card for your household;**
- **buy an item and discard the contents in order to get the return deposit for the container;**
- **resell a purchased product for cash or exchange a purchased product for consideration other than eligible food; or**
- **purchase food on credit.**

If you intentionally break any of these rules, you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); fined up to $250,000, 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 1st violation, permanently for the 2nd 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.

BY MY SIGNATURE BELOW, I DECLARE:

- I read the information at the beginning of this application and the Change Reporting and Penalties section of this application.
- I understand that if I refuse to cooperate with any review of my eligibility, including a 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 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 in order to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- As a condition of receiving TANF, I agree to assign all of my rights to financial support paid to me and to anyone for whom I am receive TANF. After my application for TANF is approved, I agree to give any support payments I receive to the Division of Child Support Enforcement.
- I authorize the Department of Social Services and refugee service contractors to obtain any verification necessary to both determine and review financial assistance eligibility. 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.
- As an applicant for Auxiliary Grants, I understand that my application will be evaluated for Medicaid. I agree to assign my rights to medical support and other third-party payments to the Department of Medical Assistance Services (DMAS). I also agree to assign the rights of anyone for whom I am applying for Auxiliary Grants to medical support and other third-party payments to DMAS. If I do not agree to assign these rights, I will be ineligible for Medicaid.
- I understand that, to the extent allowed by federal law, information about this application may be shared with agencies under the Secretary of Health and Human Resources for Virginia. Information about applicants for and recipients of services may be shared to: 1) streamline administrative processes and reduce administrative burdens on the agencies; 2) reduce paperwork and administrative burdens on applicants and recipients; and 3) improve access to and the quality of services provided by the agencies.
- I understand that different state agencies provide different services and benefits. Each agency must have specific information to determine eligibility services and benefits.
  ❑ **I allow** ❑ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, and the Department for Aging and Rehabilitative Services. I can withdraw this authorization at any time by notifying my eligibility worker.

  I filled in this application myself ❑ **YES** ❑ **NO.** If **NO**, it was read back to me when completed. ❑ **YES** ❑ **NO.**

_____	_____	_____	_____
Applicant's Signature or Mark	**Date**	**Witness To Mark or Interpreter**	**Date**

_____	_____
Signature of the Spouse or Authorized Representative	**Date**

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

_____	_____	_____
Name of Person Completing Application	**Date**	**Address**

_____	_____	_____
Primary Telephone	**Alternate Telephone**	**Relationship to Applicant**

AGENCY USE ONLY	
Case Name	Case Number
Locality	Date Received
Date of Interview:	❑ In office ❑ Telephone
Interviewer	Program (s)

APPLICATION FOR BENEFITS

FORM NUMBER - 032-03-1100

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

Case Number _____

Date Received _____

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), 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) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

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

3

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

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

4

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

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

5

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

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

6

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person 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: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

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

❑ YES ❑ NO 1. 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 2. Have you or anyone for whom you are applying ever been disqualified from receiving TANF (AFDC) or SNAP benefits? If YES, explain: _____

❑ 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. Have you or anyone for whom you are applying ever been convicted of a felony as an adult on or after February 8, 2014 for the following:

e. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
f. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
g. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
h. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, who? _____.
If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

B. RESOURCES

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

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

Yes	No		Yes	No		Yes	No	
❑	❑	Cash $_____	❑	❑	Checking, Savings	❑	❑	Credit Union
❑	❑	401K, 403B, etc.	❑	❑	Promissory notes	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Deeds of Trust
❑	❑	Deferred Compensation Plan	❑	❑	Uniform Gift to Minor Account	❑	❑	Retirement accounts
❑	❑	Keogh Plan	❑	❑	Certificate of Deposit (CD)	❑	❑	Trust funds
❑	❑	Stocks or bonds	❑	❑	Pension plans	❑	❑	ABLE Account
❑	❑	Other _____						

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

a.

Owner Name (last, first, middle initial) | **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution | **Account Type** | **Account Number** | **$ Balance**

Address of Bank or Institution

b.

Owner Name (last, first, middle initial) | **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution | **Account Type** | **Account Number** | **$ Balance**

Address of Bank or Institution

❑ YES ❑ NO 2. Has anyone received or expect to receive winnings of $3,500 or more from lottery or gambling? If **YES**, explain: _____

❑ YES ❑ NO 3. 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:

Yes	No		Yes	No		Yes	No	
❑	❑	Wages/Salary	❑	❑	Earned Sick Pay	❑	❑	Self-employment
❑	❑	Contract Income	❑	❑	Babysitting/Adult or child care	❑	❑	Any other money from working
❑	❑	Vacation Pay	❑	❑	Farming/Fishing			
❑	❑	Commissions, Bonuses, Tips	❑	❑	Odd jobs			

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule**: ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm/dd/yyyy)

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule**: ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm/dd/yyyy)

INCOME (continued)

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

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

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

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

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

_____

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

_____

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

_____

D. FINANCIAL ASSISTANCE FOR CHILDREN

❑ YES ❑ NO 1. Has the absent parent(s) begun supporting the children or changed the amount of support?

If **YES**, explain: _____

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

_____

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

_____

E. SNAP BENEFITS

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

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

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for SNAP benefits ❑ Receive correspondence ❑ Receive or use SNAP benefits

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

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

_____

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

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

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

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

6a How do you heat your home? _____

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

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

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

_____

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

USDA Nondiscrimination Statement

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

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

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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

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

This institution is an equal opportunity provider.

Commonwealth of Virginia Voter Registration Agency Certification

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

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

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

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

_____	_____	_____
Applicant Name	Signature	Date

---

for agency use only

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

_____	_____
Agency Staff Signature	Date

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)

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.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

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 _____

RENEWAL APPLICATION FOR AG, SNAP AND TANF

FORM NUMBER - 032-03-729A

PURPOSE OF FORM - To record a household's situation in order to renew or recertify eligibility.

USE OF FORM – This application is limited to renewal or recertification. This application may not be used in lieu of an application to apply for initial benefits, to reapply for benefits after a lapse in certification, or to protect the date of application. For AG, this application must be accompanied by Auxiliary Grant Supplemental Renewal Application (032-03-729C) to be a valid application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – This application must be completed at the time of the eligibility review. The completed application must be filed in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORM – The renewal application must be completed in its entirety, depending on the program requested. For example, the Resources section is needed for AG and SNAP but this section may be omitted for TANF renewals. For an application for AG only, the TANF and SNAP sections may be omitted.

Commonwealth of Virginia
Department of Social Services

EVALUATION OF ELIGIBILITY

1. GENERAL INFORMATION

CASE NAME	CASE NUMBER	PROGRAM	APPLICATION DATE	INTERVIEW DATE
SECONDARY CASE NAME	SECONDARY CASE NUMBER			
IDENTITY (NAME)	VERIFICATION			

HEAD OF HOUSEHOLD ADULT PARENT/PARENTAL CONTROL? ☐ Y ☐ N DESIGNATED BY HH ☐ AGENCY	FACE-TO-FACE INTERVIEW ☐ Y ☐ N IF NO, REASON: Telephone Interview? ☐ Y ☐ N

ADDRESS	SECONDARY ADDRESS TYPE		INSTITUTIONAL STATUS Date NF ☐ CBC ☐ ACR ☐
VERIFICATION/REMARKS	VIRGINIA RESIDENT? ☐ Y ☐ N	ACR/AFC RATE:	DMAS-96 ☐ Y ☐ N SAR ☐ Y ☐ N

2. MEMBER INFORMATION

	HH/UNIT MEMBERSHIP CHECK (✓) IF INCLUDED						PERMANENT VERIFICATIONS CHECK (✓) IF REQ. MET				SNAPET/ESP/VIEW REGISTRATION OR REFERRAL	ATENDING SCHOOL?	DEPRIVATION (MED – ONLY EFF 7/1/99)	IMMUNIZATION REQUIREMENT MET?
NAME OR MBR#	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
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

NAME	PROGRAM	REASON FOR EXCLUSION, DISQUALIFICATION OR INELIGIBILITY	TIME PERIOD

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

3. MEDICAID

RETROACTIVE DETERMINATION NECESSARY? ☐ Y ☐ N RETROACTIVE PERIOD	POTENTIALLY PROTECTED MEMBERS PROTECTED MEMBERS (INCLUDED STATUS)	COMMUNITY SPOUSE? ☐ Y ☐ 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 TRUST FUNDS ☐ Y ☐ N PENSION PLANS 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

MBR	TYPE	AMOUNT	ADDITIONAL EXPLANATION, VERIFICATION, CALCULATIONS	PROGRAM(S)		
			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.	VERIFCIATION
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? ☐ Y ☐ N

13. DIVERSIONARY ASSISTANCE PROGRAM

Loss/Delay of Income ☐ Y ☐ N TANF Requirement Met? ☐ Y ☐ N

Emergency Need $ Type

TANF $ Payment $ Date Issued
(Max 4 months)

Vendor Payment Issued to:

TANF Period of Ineligibility:

Diversionary Assistance Ineligibility (60 mos.) Ends:

Acceptance Signed: ☐ Y ☐ N Date:

EVALUATION:

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 SNAP MEDICAID
DATE GIVEN: BOOKLET HOTLINE 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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

PARTIAL REVIEWS AND CHANGES

CASE NAME	CASE NUMBER	FIPS

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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

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: **804-692-2198**

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, of 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

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

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

Central VA Legal Aid Society
229 N. Sycamore Street
Petersburg VA 23803
804-862-1100 800-868-1012

Legal Aid Justice Center
626 East Broad Street, Suite 200
Richmond, VA 23219
804-643-1086

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

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

Legal Services of Northern VA
3401 Columbia Pike, Suite 301
Arlington VA 22204
703-778-6800 866-534-5243

Legal Services of Northern VA
9240 Center Street
Manassas VA 20110
703-778-6800 866-534-5243

Rappahannock Legal Services, Inc.
311 Virginia Street
Tappahannock VA 22560
804-443-9394

Southwest VA Legal Aid Society, Inc.
16932 West Hills Drive
Castlewood VA 24224
276-762-9354

Virginia Legal Aid Society, Inc.
217 E. Third Street
Farmville VA 23901
434-392-8108

Virginia Legal Aid Society
519 Main Street
Danville VA 24541
804-799-3550

Blue Ridge Legal Services, Inc.
303 S. Loudoun Street, Suite D
Winchester VA 22604
540-662-5021

Central VA Legal Aid Society
101 West Broad Street, Suite 101
Richmond VA 23220
804-648-1012 800-868-1012

Legal Aid Justice Center
237 N. Sycamore Street, Suite A
Petersburg, VA 23803
804-862-2205

Legal Aid Justice Center
6066 Leesburg Pike, Suite 520
Falls Church, VA 22041
703-778-3450

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

Legal Services of Northern VA
10700 Page Avenue, Suite 100
Fairfax VA 22030
703-778-6800 866-534-5243

Legal Services of Northern VA
8-A South Street, SW
Leesburg VA 20175
703-778-6800 866-534-5243

Legal Services of Northern VA
8305 Richmond Highway, Suite 17B
Alexandria, VA 22309
703-778-6800 866-534-5243

Rappahannock Legal Services, Inc.
500 Lafayette Boulevard, Suite 100
Fredericksburg VA 22401
540-371-1105

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

Virginia Legal Aid Society, Inc.
16 Liberty Street Extension
Martinsville VA 24112
434-799-3550

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

Central VA Legal Aid Society
1010 Preston Avenue
Charlottesville VA 22903
434-296-8851 800-390-9983

Legal Aid Justice Center
6066 Leesburg Pike, Suite 520
Falls Church, VA 22041
703-778-3450

Legal Aid Society of Roanoke Valley
132 Campbell Avenue SW
Suite 200
Roanoke VA 24011
540-344-2088

Legal Aid Society of Eastern VA
36314 Lankford Highway, Suite 4
Belle Haven VA 23306
757-442-3014

Legal Services of Northern VA
100 N. Pitt Street, Suite 307
Alexandria VA 22314
703-778-6800 866-534-5243

Legal Services of Northern VA
500 Lafayette Boulevard, Suite 140
Fredericksburg VA 22401
703-778-6800 866-534-5243

Rappahannock Legal Services, Inc.
1200 Sunset Lane, Suite 2122
Culpeper VA 22701
540-825-3131

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

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

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

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. Submit the application either in person, through an authorized representative, online at https://commonhelp.virginia.gov/access/, by fax, by mail, or by telephone at 855.635.4370.

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.

This institution 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 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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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
❑ Water ❑ Electricity for Air Conditioning
❑ Garbage ❑ Sewer ❑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?

Countable Income $_____
Countable 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 MIRGRANT & 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 SERVICE CHECKLIST

FORM NUMBER - 032-03-0718

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

USE OF FORM - May be used for a new application, reapplication or a late recertification to identify households eligible for expedited service processing.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - File in the case record.

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

Local department of social services 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 service, the EW must conduct an interview, determine eligibility, and authorize benefits, if eligible, within the expedited service processing period.

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

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CHECKLIST OF NEEDED VERIFICATIONS

Name Address

Case Number	
Program(s)	Date
Worker	Telephone FAX

In order for us to see if you are eligible for 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 30th 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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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-Unattached Child benefits at the same time, and then are approved for TANF or GR-Unattached Child 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 benefit amount , we will make the changes without another 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 OF $ _____.

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** **1-866-534-5243**

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 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 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited benefits. 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.

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 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.

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 SNAP 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 **automated** notices are used.

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

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.

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.

Enter the effective date of the proposed action. For actions that require advance notice, enter either the last day of the month or the first day of the next month, provided that day is at least 10 days from the date the notice is given or mailed.

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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

ADVANCE NOTICE OF PROPOSED ACTION

Case number	Program

Date of Mailing:

Call **1-866-534-5243**, Legal Aid Hotline, for free legal assistance.

ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.

☐ SNAP Benefits

Your SNAP allotment will be: ☐ Reduced ☐ Suspended ☐ Terminated

Effective Date:	Amount of reduction: From: To:	Eligibility Worker:	Telephone:

Reason for Proposed Action:
Manual Reference

☐ FINANCIAL ASSISTANCE

Your assistance check will be : ☐ Reduced ☐ Suspended ☐ Terminated

Effective Date:	Amount of Reduction: From: To:	Eligibility Worker:	Telephone:

Manual Reference: Reason for proposed action:

☐ VIEW Termination – The TANF case is closed until you reapply and are found eligible for TANF/TANF-UP
☐ VIEW Sanction - your household's entire TANF or TANF-UP benefits will be suspended for the above reason.
☐ 1ST Sanction - 1 month and compliance ☐ 2ND Sanction - 3 months and compliance ☐ 3RD Sanction - 6 months and compliance
YOU HAVE 10 DAYS AFTER THE DATE OF THIS NOTICE TO CONTACT YOUR VIEW WORKER TO SHOW DOCUMENTED GOOD CAUSE.

VIEW worker's name Telephone:

☐ 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. 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.

☐ 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.

☐ MEDICAID OR FAMIS PLUS

☐ No longer eligible for full Medicaid. Approved for limited Medicaid coverage:
Qualified Medicare Beneficiary (QMB) Special Low-Income Medicare Beneficiary (SLMB) Qualified Individual (QI)
☐ No longer eligible for Medicaid. ☐ No longer eligible for FAMIS PLUS.
☐ 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:
☐ 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_____, bring your bills to this agency and your eligibility will be reviewed.
☐ Other: _____

If you disagree with the action we have proposed, you may appeal the decision. If you appeal this action before _____, the change will not go into effect and your benefits for SNAP, General Relief-Unattached Child, 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, or FAMIS PLUS 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 Refugee Assistance, Medicaid, or FAMIS PLUS actions. You may appeal TANF, General Relief-Unattached Child, or Auxiliary Grants Program actions within 30 days of this notice. You may appeal SNAP 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 hearings 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 or FAMIS PLUS 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited benefits. 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.

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. You will get the hearings 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 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. For SNAP, this date must be at least 10 days from the date the form is mailed or given. For reduced **or suspended** benefits, the effective date will be the first day of the next month. When benefits are terminated, the effective date will be the last day of the month.

Examples

(1) An Advance Notice of Proposed Action is mailed on October 15; the effective date of the proposed action would be November 1 if benefits are being reduced **or suspended**. The effective date of the proposed action would be October 31 if benefits are terminated..

(2) An Advance Notice of Proposed Action is mailed on October 25; the effective date would be December 1 for a reduction **or suspension** of benefits or November 30 for a termination of benefits.

APPEALS -

a. For SNAP and Financial Services actions, enter the date that is 10 days from 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.

Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)

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 https://commonhelp.virginia.gov/access/.

☜ **Please use only one method to renew.**

☐ 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.

Alternate Agency Address:

Eligibility Worker	Date	❑ Mailed ❑ Given

USDA NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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NOTICE OF EXPIRATION

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

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 notice at the time of certification. All other households must have the expiration notice 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. Allow two days for delivery in addition to the postmark date when the form is mailed.

NUMBER OF COPIES - Two

DISPOSITION OF FORM - The agency must give or mail the completed Notice of Expiration to the household and retain a copy.

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. 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 15th calendar day of the last month of certification.

Indicate whether the form was mailed or given to the recipient on the date indicated.

Enter information regarding an interview date and time.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CHANGE REPORT

CASE NAME	CASE NUMBER
WORKER NAME	LOCALITY
AGENCY TELEPHONE NUMBER	
CERTIFICATION PERIOD	YOUR HOUSEHOLD SIZE

You must report changes that occur in your household to ensure that your Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefit amount is correct. You may use this form to report changes listed below for your SNAP or TANF case. You may also report changes online at https://commonhelp.virginia.gov/access/. Report changes within 10 days from when they occur but, no later than the 10th day of the next month. If you do not report changes, you may have to repay benefits you receive incorrectly, be fined, or prosecuted.

Please note changes on the next page. Please provide proof if there are changes.

- **If you receive TANF, tell us if:**
  - Your address changes;
  - A child, including a newborn, or the father, or the mother of a child, enters or leaves your home;
  - There are changes that may affect your participation in VIEW, such as changes in income, employment, education, training, transportation, and child care; or
  - All the income for your household before taxes goes over the 130% Gross Income Limit listed in Chart A below.

Your case has been certified effective - based on a household size of .

- **If you receive SNAP as part of the Elderly Simplified Application Project (ESAP) and your certification period is 36 months (three years), tell us if:**
  - There is a change in the number of people in your household;
  - You have lottery or gambling winnings of $4,250* or more; or
  - You or any member of your household starts getting income from working.

- **If you receive SNAP and your certification period is five (5) months or longer, tell us if:**
  - All the income for your household before taxes goes over the limits in Chart B below unless the note for Chart A applies.
  - The number of work hours goes under 20 per week for persons who are between the ages of 18-53 if there are no children in the home.
  - You have lottery or gambling winnings of $4,250* or more.

- **If you receive SNAP and your certification period is for one (1) month to four (4) months, tell us if:**
  - There is a change in the number of people in your household;
  - Your address changes, including shelter expenses that change resulting from the move;
  - The obligation to pay child support changes or the amount paid to someone outside the household changes;
  - Your liquid resources, such as bank accounts, cash, bonds, etc. are $2,750 or $4,250* or more;
  - You have lottery or gambling winnings of $4,250* or more;
  - The number of work hours goes under 20 per week for persons who are between the ages of 18-53 if there are no children in the home; or
  - There are changes in income:
    - There are income changes of more than $125 except, you do not have to tell us if your TANF income changes if your TANF case is in Virginia;
    - The source of your income changes, including if you start or stop a job: or
    - Your job switches from full-time to part-time or part-time to full-time.

Chart A (Gross Income Limit 130%)*					**Chart B (Gross Income Limit 200%)***				
HH Size	Monthly	Weekly	Every 2 Weeks	Twice a Month	HH Size	Monthly	Weekly	Every 2 Weeks	Twice a Month
1	**$ 1,580**	**$ 367.44**	**$ 734.88**	**$790**	**1**	**$ 2,430**	**$ 565.11**	**$1,130.23**	**$ 1,215.00**
2	**2,137**	**496.97**	**993.95**	**1,068.50**	**2**	**3,287**	**764.41**	**1,528.83**	**1,643.50**
3	**2,694**	**626.51**	**1,253.02**	**1,347.00**	**3**	**4,143**	**963.48**	**1,926.97**	**2,071.50**
4	**3,250**	**755.81**	**1,511.62**	**1,625.00**	**4**	**5,000**	**1,162.79**	**2,325.58**	**2,500.00**
5	**3,807**	**885.34**	**1,770.69**	**1,903.50**	**5**	**5,857**	**1,362.09**	**2,724.18**	**2,928.50**
6	**4,364**	**1,014.88**	**2,029.76**	**2,182.00**	**6**	**6,713**	**1,561.16**	**3,122.32**	**3,356.50**
7	**4,921**	**1,144.41**	**2,288.83**	**2,460.50**	**7**	**7,570**	**1,760.46**	**3,520.93**	**3,785.00**
8	**5,478**	**1,273.95**	**2,547.90**	**2,739.00**	**8**	**8,427**	**1,959.76**	**3,919.53**	**4,213.50**
Additional members	**+557**	**+129.53**	**+259.06**	**+278.50**	Additional members	**+857**	**+199.30**	**+398.60**	**+428.50**

*Amounts are valid through ***9/30/2024***.

Add together the gross income for all of the people in your household. New income total $_____

Note: Chart A applies to SNAP households that have a member who cannot get SNAP benefits because of a felony conviction, a conviction for a SNAP intentional program violation, or because of an employment and training requirement. Please contact me at the number above if you are not sure which chart applies to you or if you need help completing this form.

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DETAILS ON CHANGES THAT HAVE OCCURRED

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

CHANGE IN YOUR ADDRESS

New Address (Street, Apt. Number)		City, State, ZIP

CHANGE IN SHELTER EXPENSES THAT RESULT FROM THE MOVE

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 LEGALLY OBLIGATED CHILD SUPPORT PAID TO ANOTHER HOUSEHOLD

-Person paying support	Person receiving support	Amount legally obligated	Amount paid
		$ per	$ per

CHANGE IN YOUR LIQUID RESOURCES SUCH AS CASH, BANK ACCOUNTS, BONDS, ETC. THAT REACH OR EXCEED $2,750 OR $4,250* (*$4,250 applies only if someone in your household is 60 years of age or older or who is permanently disabled.)

Name	Account Type	Balance

RECEIPT OF LOTTERY OR GAMBLING WINNINGS OF $4,250 OR MORE

Name	Gross Amount Received Where Received	When Received

CHANGE IN THE NUMBER OF WORK HOURS IN A WEEK GOES UNDER 20 FOR MEMBERS WHO ARE BETWEEN THE AGES OF 18-50 IF THERE ARE NO CHILDREN IN THE HOME.

Name	Number of Work Hours

CHANGE IN INCOME OF MORE THAN $125 (money from working or from sources such as Social Security,SSI, pensions, etc.)

Name	Income Type	Amount

CHANGE IN INCOME SOURCE - HAVE YOU STARTED OR STOPPED RECEIVING INCOME?

Name	Source	Date Started/Stopped Number Of Hours If Started Working

HAVE YOU CHANGED FROM FULL-TIME TO PART-TIME OR PART-TIME TO FULL-TIME?

Name	Employer	Number Of Hours

OTHER CHANGES

_____ _____

Person completing this form Date

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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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 **1-866-534-5243**

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 hearings 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited benefits. 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.

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 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.

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

Case Name:_____

TO: _____ _____

Case Number:_____

Agency:_____

_____ _____

Date:_____

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

_____ 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. **This form is also not intended to be sent to clarify circumstances the household is not required to report unless the partially reported change suggests the household is ineligible for SNAP benefits. See Part XIV.A.1.**

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
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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 (5th) of the month for your SNAP case. Please note the information checked below.

( ) We have not received an Interim Report form from you. Complete the Interim Report form that was sent to you. When you send the Interim Report form in, please make sure you answer every question, give us all the information the report asks for, and sign and date the report.

( ) 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. Please send in the following:

_____

_____

_____

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 case will 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. For more information about the Interim Report process, see Part 14.C of the SNAP Manual.

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

Worker	Telephone Number	For Free Legal Advice Call **1-866-534-5243**

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 90 days for SNAP benefits or 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.

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.

USDA NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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 completing the Interim Report or for providing required verification.

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 households file an incomplete form or fail to submit needed information, the agency must return the original Interim Report to the household along with this action form. If households fail to file an Interim Report altogether, the agency may send another copy of the report to the household along with the action form. **Send the Interim Report Form-Request for Action by the 15th of the month the Interim Report was due if the household fails to return a completed Interim Report.**

INSTRUCTIONS FOR PREPARATION OF FORM – Complete identifying case and agency information at the top of the form and the action required by the household. Sign and date the form.

Commonwealth of Virginia
Department of Social Services

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 #	NAME LAST 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 O 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

CASE NAME	LOCALITY
CASE NUMBER	DATE

FOOD REPLACEMENT REQUEST

In order for us to consider replacing the value of your destroyed food, you must complete and return this form. You must return the completed form within 10 days of the date the food was destroyed or within 10 days of the date above.

Case Name	Address
Value of the destroyed food	Was the destroyed food bought with SNAP benefits? _____Yes _____No
When was the food destroyed or damaged?	
How was food destroyed or damaged? **If your food was destroyed or damaged by a loss of electrical power, please provide the following information:** Electric Power Company: _____ Account Name: _____ Account Number: _____	
I certify that the household listed above experienced a destruction of food bought with SNAP benefits in the month of _____, 20_____.	
Signature	Date

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

Food Replacement Request

FORM NUMBER - 032-03-0388

PURPOSE OF FORM - This form will allow the local agency determine the value of food destroyed so that the agency may provide additional SNAP benefits to cover the value of food destroyed.

USE OF FORM - The agency must 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 food destroyed. A household member must sign and date the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF BENEFIT PROGRAMS

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. [ ] Repay SNAP Claim of $_____ from EBT account

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. Repaid $_____ to SNAP Claim on _____/_____/_____.

Completed by _____ _____
Issuance/Administrative Worker Date

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 **VaCMS inquiry** 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 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 _____/_____/_____
❑ Copy Sent to Child Care Worker

==========

Name of Participant_____ Participant's Client ID # _____
Case Name _____ ❑ SNAPET ❑ TANF ❑ TANF-UP
Case Number _____

==========

❑ 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)
❑ Employment/benefit reduction/savings information provided below
❑ Other: _____.
Effective Date: _____/_____/_____.
❑ Individual removed from the SNAP household because _____
_____
Effective Date: _____/_____/_____.
❑ Effective with payment on _____/_____/_____, benefits will be reduced from $_____ to $_____.

==========

❑ Individual appealed TANF sanction. Case remains open until appeal resolved.
❑ TANF Sanction ended effective _____/_____/_____.
❑ 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 _____/_____/_____.

==========

❑ Individual is a refugee. Contact _____ (refugee resettlement agency) at _____ (telephone) before conducting VIEW/SNAPET initial assessment.

==========

❑ 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 _____/_____/_____
❑ Copy Sent to Child Care Worker

==========

Name of Participant_____ Participant's Client ID # _____
Case Name _____ ❑ SNAPET ❑ TANF ❑ TANF-UP
Case Number _____

==========

❑ 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 TANF for (check appropriate answer)
❑ 1 month and compliance ❑ 3 months and compliance ❑ 6 months and compliance
❑ SNAPET case will close effective_____/_____/_____.
❑ Please provide the dollar amount of SNAP reduction due to employment or sanction.
❑ 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 _____
_____
_____

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 is applicable to the situation. If the worker needs to communicate information that is not listed on the form, check “Other” and enter the information.

Commonwealth Of Virginia
Department Of Social Services
Supplemental Nutrition Assistance Program (SNAP)

SNAP Sanction Notice for Non-Compliance with a Work Requirement

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.

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 _____.
- ❑ 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 _____.

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: **1-866-534-5243**		

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 haring 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 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited SNAP benefits. 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.

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 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.

SNAP SANCTION NOTICE FOR NONCOMPLIANCE WITH A WORK REQUIREMENT

FORM NUMBER - 032-03-0174

PURPOSE OF FORM - To notify households or individuals of the **reduction or termination of their SNAP benefits because of the** disqualification penalty caused by quitting a job or reducing work without good cause**.**

USE OF FORM - The EW must complete this form if an individual voluntarily quit a job or reduced work hours without good cause.

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 findings of voluntary quit or work reduction. 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.

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 Date

An investigation of your _____ Child Care Subsidy, your _____ Supplemental Nutrition Assistance Program (SNAP), or your _____ Temporary Assistance for Needy Families (TANF) 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 Child Care Subsidy, SNAP, or TANF 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.

Child Care Subsidy

_____ 3 months, 1st violation _____ 12 months, 2nd violation _____ permanently, 3rd violation

SNAP

_____ months, 1st violation _____ months, 2nd violation _____ permanently, 3rd violation
_____ Other (Specify)

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.

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**

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 Child Care Subsidy, 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 Child Care, SNAP, or TANF benefits to which you are not entitled. Even if your application is denied, you can be found guilty.
- Hiding information or not telling all the facts in order to get Child Care, 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

	Case Name	
	Case Number	
	Locality	Date

The Notice of Intentional Program Violation told you that we suspect you intentionally violated a program rule for ☐ Child Care, ☐ Supplemental Nutrition Assistance Program (SNAP), or ☐ Temporary Assistance for Needy Families (TANF). The Notice listed the evidence against you.

The amount of benefits overpaid: $_____ Child Care $_____ SNAP $_____ TANF

This form is a WAIVER of an Administrative Disqualification Hearing (ADH).

IF YOU CHOOSE TO SIGN THIS WAIVER, you may 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

You may 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.

All members of your SNAP household are responsible for repaying the benefits overpaid.

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

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 Child Care, 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 Child Care, SNAP, or TANF benefits to which you are not entitled. Even if your Child Care, SNAP, or TANF application is denied, you can be found guilty.
- Hiding information or not telling all the facts in order to get Child Care, 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 Child Care, SNAP, or TANF benefits. The length of the disqualification for Child Care, 3 months for the first offense; 12 months for the second offense; and permanently for the third offense. For SNAP, the disqualification 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 – **Two.**

DISPOSITION OF FORM - The local agency must provide a copy of the completed waiver 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. 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.

Commonwealth of Virginia
Department of Social Services
REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

	Locality
	Case Number
	Case Number

☐ Child Care Violation 1 2 3	☐ SNAP Violation 1 2 3	☐ TANF Violation 1 2 3
IPV Period	IPV Period	IPV Period
Overpayment Amount $	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 Child Care Subsidy, Supplemental Nutrition Assistance Program benefits or Temporary Assistance for Needy Families 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

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 department of social services 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 department 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 department 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 ☐ Child Care Subsidy case, ☐ Supplemental Nutrition Assistance Program (SNAP) case, or ☐Temporary Assistance to Needy Families (TANF) case.

The department believes you committed an intentional violation of a program rule because (continue on reverse, if necessary):

The department has the following evidence to support the case against you (continue on reverse, if necessary):

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 the hearing officer finds you intentionally violated a program rule, you will be disqualified from receiving benefits for the period shown below (the items checked apply to you):

Child Care Subsidy

☐ 3 months, 1st violation ☐ 12 months, 2nd violation ☐ permanently, 3rd violation

SNAP

_____ months, 1st violation _____ months, 2nd violation ☐ permanently, 3rd violation ☐ Other (Specify)

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.

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. If you or your representative fails 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 good reason for your failure to appear in order to receive a new hearing. An explanation of the steps involved in a hearing is enclosed.

(continued on next page)

ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING

Even though this 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 or overissuance. If you have any questions or need the name and phone number of someone who can give you free legal advice, call the local social services office at: .

Hearing Officer	Phone Number

(Continuation of explanations from page 1, if necessary)

YOU HAVE THE RIGHT TO:

* Look at the evidence that will be used at the hearing both before and during the hearing.
Please call the local social service department if you wish to look at the evidence before the hearing. The department will provide a free copy of the portions of your case file that relate to the hearing upon request.

* Present your own case or have someone present your case for you, such as a lawyer, friend, relative, or community worker.

* Bring your own witnesses.

* Argue your case freely.

* Question or deny any evidence or statements made against you.

* Bring any evidence you may have that would support your case.

* Remain silent concerning the charge(s) against you.

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
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 Child Care Subsidy, Supplemental Nutrition Assistance Program (SNAP), o Temporary Assistance for Needy Families (TANF) r rule.

☐ DID COMMIT an intentional violation of a Child Care Subsidy, SNAP, or TANF rule.

If you did commit an intentional program violation, the local department of social services will disqualify you from receiving benefits for the time shown below:

Child Care Subsidy

☐ 3 months, 1st violation ☐ 12 months, 2nd violation ☐ permanently, 3rd violation

SNAP

_____months, 1st violation _____ months, 2nd violation _____ permanently, 3rd violation
_____Other (Specify)_____

TANF

☐ 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 you apply for TANF benefits and are found eligible again.

The local department of social services is responsible for notifying you of the date the disqualification will take effect. Also, the local department of social services is responsible for notifying 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 Child Care Subsidy, SNAP, or TANF benefits your household was not eligible to receive. The local department of social services is responsible for sending you a letter requesting repayment.

If you are not satisfied with the hearing decision, you can ask for a review of this decision by the Commissioner, Virginia Department of Social Services by sending 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

Hearing Officer	Date

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 department of social services. The hearings 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 _____ Child Care Subsidy, _____ Supplemental Nutrition Assistance Program (SNAP) or _____ Temporary Assistance for Needy Families (TANF) program.

_____ has been disqualified for the amount of time shown:

Child Care _____ 3 months _____ 12 months _____ Permanently

SNAP _____ months _____ Permanently _____Other (specify)_____

TANF _____ 6 months _____12 months _____ Permanently

The reason for the disqualification is shown below:

_____ Court of appropriate jurisdiction found the person guilty of committing an intentional program violation of _____ Child Care, _____ SNAP, or _____ TANF policy.

_____ An Administrative Disqualification Hearing found the person guilty of committing an intentional program violation of _____ Child Care, _____ SNAP, or _____ TANF 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:

_____For Child Care Subsidy program, effective _____.

_____For SNAP benefits, effective _____.

The SNAP allotment will change from $ _____ to $_____.

_____ From the TANF program, effective _____.

_____If this blank is checked, the disqualification will begin when the person next applies for and is found eligible for TANF.

The TANF payment will change from $ _____ to $_____.

Worker	Telephone	For Free Legal Advice Call 1-866-534-5243

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 department of social services 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 disqualified individual.

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF SOCIAL SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

MISSED INTERVIEW NOTICE

TO:

Case Name:______

Agency:______

Case Number:______

Date: _____

You missed the interview to discuss your SNAP application on _____. You must reschedule the interview or we will deny your application if no interview takes place within 30 days of your application date. Your application for SNAP benefits was filed ______

Please call ______________to schedule the interview.

Eligibility Worker

Telephone number

032-03-0419-03-eng (1/2017)

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 90 days for SNAP benefits or 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.

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.

USDA NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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 30th day following the application filing date.

NUMBER OF COPIES - Two.

DISPOSITION OF FORM - The agency must provide the form to the household and retain a copy of the completed form or document the case to show that the form was sent.

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 30th day after the application date or the last business day before the 30th day if the 30th day falls on a weekend or holiday.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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 IF YOUR HOUSEHOLD'S INCOME GOES OVER THE LIMIT OF $_____.

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 UNINTERUPTED 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 ☜ **Please use only one method to renew.**
- online at https://commonhelp.virginia.gov/access/.

❑ 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 **1-866-534-5243**

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 haring 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 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited SNAP benefits. 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.

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 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.

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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

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 hearings 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 about the denial of your entitlement to expedited SNAP benefits. During the conference, the agency must explain why you were not entitled to expedited SNAP benefits. 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.

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. You will get the hearings 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 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.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CASE RECORD TRANSFER FORM

TO: DEPARTMENT OF SOCIAL SERVICES

_____
COUNTY/CITY

_____
ADDRESS

FROM: DEPARTMENT OF SOCIAL SERVICES

_____
COUNTY/CITY

_____
ADDRESS

I. TRANSFERRING LOCALITY CASE INFORMATION

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: _____

II. CONFIRMATION OF RECEIPT & DISPOSITION

CASE RECORD WAS RECEIVED _____ DETERMINED: ☐ ELIGIBLE ☐ INELIGIBLE

EFFECTIVE ____/____/____ FOR _____
DATE 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.

Case Name _____
Case Number _____

Rights and Responsibilities

❑ I declare that I reviewed a listing of my rights and responsibilities in writing about applying for or receiving public assistance benefits such as Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits.

❑ I declare that a representative of the _____ agency discussed rights and responsibilities with me.

_____	_____	_____
Printed Name	Signature	Date

Agency Use

❑ I declare that I discussed applicant and recipient rights and responsibilities with _____ on _____ during a telephone interview or other contact.

_____	_____	_____
Printed Name	Signature	Date

Rights and Responsibilities

PURPOSE AND USE OF FORM – May be used to document that an applicant was provided written and verbal guidance on rights and responsibilities for applying and receiving public assistance benefits.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – The case file must contain documentation that the local agency provided each applicant with information about the rights and responsibilities for applying and receiving public assistance benefits. The agency must present the information in writing and verbally. Written information is included as part of the benefit application forms. Applicants must acknowledge receipt of the rights and responsibilities information.

The local agency may use the Rights and Responsibilities form to have an applicant acknowledge receipt of rights and responsibilities information or to document that information was provided during a telephone interview or other contact with an applicant.

INSTRUCTIONS FOR PREPARATION OF FORM –

The applicant must complete the top portion of the form to acknowledge receipt of rights and responsibilities information in writing or verbally. The applicant must sign and date the form.

The local agency worker who provides the verbal presentation must complete the bottom portion of the form to acknowledge that rights and responsibilities information was presented. The worker must record the name of the applicant or other household member with whom a telephone interview was conducted and record the date the information was provided. The worker must sign and date the form.

COMPROMISING CLAIMS WORKSHEET

Name: _____ Claim Number: _____

Claim amount: _____ Claim Balance: _____

To ensure that we properly consider your financial circumstances, please provide documentation of your household's income and expenses. Please provide a copy of recent pay statement or other documentation

Monthly Amount of Income for All Household Members:

Earnings:	$_____	Social Security:	$_____
Alimony:	$_____	Child Support:	$_____
Other Income:	$_____	Pensions/retirement:	$_____

Resources:

Checking Account $_____

Savings: Account $_____

Market value of stocks, bonds, mutual funds and other investments: $_____

Monthly Expenses:

Rent/ Mortgage:	$_____	Electricity:	$_____
Gas:	$_____	Water/ Sewer:	$_____
Telephone:	$_____	Other Utilities:	$_____
Health Insurance:	$_____	Other Medical:	$_____
Alimony/Child support:	$_____		

_____ _____

Signature Date

Agency Use Only

Ability to Pay:

1. Total monthly income: $_____
2. 10 % of resources: + $_____
3. Combined income/resources: = $_____
4. Total expenses: - $_____
5. Available funds for payment $_____
6. 10% of available funds (line 5) $_____
7. X 3 years or 36 months $_____
8. Claims balance: $_____
9. Amount to be paid (line 7): - $_____
10. Amount to be compromised: $_____

Household size when claim established:

_____

200% Poverty Level for household

_____

Referred to TOP? Yes ❑ No ❑

❑ Compromise Approved ❑ Compromise Denied

Explanation: _____

_____ _____

Signature Date

Compromising Claims Worksheet

FORM NUMBER - 032-03-0572

PURPOSE AND USE OF FORM – May be used to document how all or a portion of a claim amount owed may be eliminated to allow a household to repay the debt within three years.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – The worksheet or other documentation must be filed with the claim information to document why the claim amount owed was or was not reduced or eliminated through compromising.

INSTRUCTIONS FOR PREPARATION OF FORM – A local agency representative must complete the identifying case/claim information. The representative must provide the worksheet to the household to complete the information about household income, resources, and expenses. Calculate the entitlement for compromising the claim in the bottom section of the worksheet by using the information supplied by the household.

COMMONWEALTH OF VIRGINIA

Case Number _____

Date Received _____

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM (TANF) APPLICATION TO ADD NEW ASSISTANCE MEMBERS

This is an application to add new assistance unit members for the TANF Program. These new members joined the family unit since the last application was filed. You may bring this application to the local Department of Social Services office or mail it to the local Department of Social Services office.

A. 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**

B. New Household Member Information

Give the following information for any new household members you are reporting for the first time or for new members you verbally reported since your original application or most recent eligibility review.

1.

Name (last, first, middle initial) | **Relationship to You** | **Date of Birth** (mm-dd-yyyy)

Social Security Number:_____ **Assistance Requested:** ❑ SNAP Benefits ❑ TANF ❑ None

Gender: ❑ Male ❑ Female **Place of Birth:**_____ (City, State, Country)

Marital Status: ❑ Married ❑ Never Married ❑ Separated ❑ Divorced ❑ Widowed **Is this Person a U.S. Citizen?** ❑ Yes ❑ No — If not a U.S. Citizen, what is your status? _____

Is this Person a Student? ❑ Yes ❑ No If **yes**, name of school _____ **Alien Registration Number** _____

Highest Grade Completed _____ **Date started living in the U.S.** (mm-dd-yyyy) ____/___/_____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White ❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White ❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

2.

Name (last, first, middle initial) | **Relationship to You** | **Date of Birth** (mm-dd-yyyy)

Social Security Number:_____ **Assistance Requested:** ❑ SNAP Benefits ❑ TANF ❑ None

Gender: ❑ Male ❑ Female **Place of Birth:**_____ (City, State, Country)

Marital Status: ❑ Married ❑ Never Married ❑ Separated ❑ Divorced ❑ Widowed **Is this Person a U.S. Citizen?** ❑ Yes ❑ No — If not a U.S. Citizen, what is your status? _____

Is this Person a Student? ❑ Yes ❑ No If **yes**, name of school _____ **Alien Registration Number:**_____

Highest Grade Completed:_____ **Date started living in the U.S.** (mm-dd-yyyy) ____/___/_____

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

3. _____ _____ _____

Name (last, first, middle initial) **Relationship to You** **Date of Birth** (mm-dd-yyyy)

Social Security Number:_____ **Assistance Requested:** ❑ SNAP Benefits ❑ TANF ❑ None

Gender: ❑ Male ❑ Female **Place of Birth:**_____
(City, State, Country)

Marital Status: ❑ Married ❑ Never Married **Is this Person a U.S. Citizen?** ❑ Yes ❑ No
❑ Separated ❑ Divorced ❑ Widowed — If not a U.S. Citizen, what is your status? _____

Is this Person a Student? ❑ Yes ❑ No **Alien Registration Number:**_____
If **yes**, name of school _____

Highest Grade Completed:_____ **Date started living in the U.S.** (mm-dd-yyyy) _____/___/_____

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 1. 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 2. Have you or anyone for whom you are applying ever been disqualified from receiving TANF (AFDC) or SNAP benefits? If YES, explain:
_____

❑ 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. Have you or anyone for whom you are applying ever been convicted of a felony as an adult on or after February 8, 2014 for the following:

a. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
b. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
c. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
d. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, who? _____.
If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

By my signature below, I declare that the household member(s) for whom I am requesting TANF or SNAP benefits, is/are either a U.S. citizen(s) or alien(s) in lawful immigration status. I declare under penalty of law that all information on this form is correct and complete to the best of my knowledge and belief. I understand that if there is a TANF or 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 to Mark or Interpreter Date

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM (TANF) APPLICATION TO ADD NEW ASSISTANCE MEMBERS

FORM NUMBER - 032-03-729B

PURPOSE OF FORM - To gather information about new household members for whom TANF assistance is requested.

USE OF FORM – This application is limited to requesting TANF assistance for new household members during the certification period. The application may also be used to apply for SNAP benefits for new members during the certification period although the request to add new household members is not required to be in writing. This application may not be used in lieu of an application to apply for initial benefits, to reapply for benefits after a lapse in certification, or to protect the date of application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – This application must be completed when new household members are added for TANF. The completed application must be filed in the eligibility case record. The application may be used to apply for SNAP benefits for new members

INSTRUCTIONS FOR PREPARATION OF FORM – The application must be completed in its entirety to request TANF assistance for new household members.

Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)
APPLICATION FOR THE ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP)

Return your completed application to:
_____ County/City DSS
_____
_____

GENERAL INFORMATION

With this application, you may apply for food assistance if:

- Everyone in the household is 60 years of age or older; or
- All household members aged 60 or older purchase and prepare food separately from other household members; and
- No member receives earnings from work.

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 there are more than 2 people living in your home and you need more space to list everyone, tell the agency you need extra pages. If you have a disability or have difficulty with English, you may receive extra help to make sure you get the assistance or services you are eligible to receive.

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.** 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.

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers, 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)
- Virginia Lottery

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:

- determine the correctness, accuracy, and truthfulness of the application;
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

Your information may also be used or disclosed to study public benefit programs, such as SNAP.

Information regarding your race and ethnicity is not required and will not affect your eligibility or benefit amount. This information is requested to be sure that program benefits are provided without regard to race, color, or national origin.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible. To qualify for Expedited Service: 1) your gross monthly income must be less than $150 and liquid resources $100 or less; 2) your monthly shelter bills must be higher than your household's gross monthly income plus your liquid resources; or 3) someone in your household must be a migrant or seasonal farm worker with little or no income and resources.

REPORTING REQUIREMENTS

You must report changes within 10 days, but no later than the 10th day of the month after the change occurs. Report these changes:

- If you have lottery or gambling winnings of $3,750 or more;
- If you have changes in the number of people in your household; or
- If you or a member of your household start to receive money from working.

SNAP RESPONSIBILITIES AND PENALTIES FOR VIOLATIONS

You must not:

- give false information or hide information to get SNAP benefits;
- trade or sell EBT cards or attempt to trade or sell EBT cards;
- use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products;
- use someone else's EBT card for your household.
- buy an item and discard the contents in order to get the return deposit for the container;
- resell a purchased product for cash or exchange a purchased product for consideration other than eligible food; or
- purchase food on credit.

If you intentionally break any of these rules, you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); fined up to $250,000, 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 1st violation, permanently for the 2nd 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.

If you refuse to cooperate with any review of eligibility, including a review by Quality Assurance, your benefits may be denied until there is cooperation.

Failure to report or verify your expenses will be seen as a statement that you do not want to receive a deduction for these expenses.

NONDISCRIMINATION STATEMENT

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

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

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

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

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights,1400 Independence Avenue, SW, Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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

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

This institution is an equal opportunity provider.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

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) ❑ Yes ❑ No

_____	_____
Agency Staff Signature	Date:

Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)

APPLICATION FOR THE ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP)

Return your completed application to:
_____ County/City DSS
_____
_____

A. APPLICANT INFORMATION. Enter 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**

Email Address | **Primary Telephone Number** | **Alternate Telephone Number**

What is the primary language spoken in your household?

Primary Method of Correspondence

You may receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov). List either a cell telephone number or an email address. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

❑ **Text** ❑ **Email Cell Phone Number** _____ **Email Address** _____

❑ YES ❑ NO 1. Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving SNAP benefits from a social services agency? If **YES,** enter the information below.
When? _____ From What County, City, or State? _____

❑ YES ❑ NO 2. 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 SNAP benefits in two or more states at the same time? If **YES**, give date and place of conviction._____

❑ YES ❑ NO 3. Have you or anyone for whom you are applying ever been disqualified from participating in SNAP? If **YES**, give date and place of all disqualifications._____

❑ YES ❑ NO 4. 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 _____

❑ YES ❑ NO 5. Have you or anyone for whom you are applying ever been convicted as an adult on or after February 8, 2014 for the following:

i. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
j. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
k. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
l. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

6. You may appoint someone to 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 a representative, please give the information below

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for SNAP benefits ❑ Receive correspondence ❑ Access or use SNAP benefits

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

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

Program Requested: If No, immigration status: _____

❑ None ❑ ESAP **US Residency Date:** __/____/____

Alien Registration Number:_____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

2

Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Program Requested: If No, immigration status: _____

❑ None ❑ ESAP **US Residency Date:** __/____/____

Alien Registration Number:_____

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 Are there others who live in your home? If **YES**,

Name of Person	**Relationship**	**Does this person buy/eat food with you?**
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

C. RESOURCES

1. Do you or anyone who lives with you have any of the following resources or assets? If **Yes,** please provide details below.

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
❑	❑	Cash $_____	❑	❑	Checking/Savings Accounts	❑	❑	Stocks or bonds
❑	❑	401K, 403B, etc	❑	❑	Certificate of Deposit (CD)	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Other

a.

Owner Name (last, first, middle initial) Co-Owner Name (last, first, middle initial)

Name of Bank or Institution | Account Type | Account Number | $ Balance

Address of Bank or Institution

b.

Owner Name (last, first, middle initial) Co-Owner Name (last, first, middle initial)

Name of Bank or Institution | Account Type | Account Number | $ Balance

Address of Bank or Institution

❑ YES ❑ NO 2. Has anyone received or expect to receive winnings of $3,750 or more from lottery or gambling? If **YES**, explain:

_____

❑ YES ❑ NO 3. Has anyone sold, transferred or given away any resources in the last 3 months? If **YES**, explain:

_____

D. INCOME

❑ YES ❑ NO 1. Do you or anyone applying for ESAP with you receive or expect to receive money from working? If **YES**,

Name of Person	$ Amount/ How Often Received?	Employer

2. Do you or anyone applying for ESAP with you receive or expect to receive any of the following? Answer yes or no below and provide the requested information.

Yes	No		Yes	No		Yes	No	
❑	❑	Social Security or SSI	❑	❑	Worker compensation	❑	❑	Room/board or Rental Income
❑	❑	VA benefits or Military Allotment	❑	❑	Unemployment benefits	❑	❑	Interest, dividends
❑	❑	Child support, alimony	❑	❑	Black Lung benefits	❑	❑	Public Assistance (TANF/GR)
❑	❑	Railroad or Other retirement	❑	❑	Insurance settlement	❑	❑	Any other type of money

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

E. EXPENSES

❑ YES ❑ NO 1. 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			
Other			

❑ YES ❑ NO 1a Do you have air conditioning in your home? How do you heat your home? _____

❑ YES ❑ NO 1b Did you receive energy/fuel assistance during this past year while living in your current home?

❑ YES ❑ NO 2. Do you or anyone in your household who is age 60 or older have any current medical expenses? If **YES**, list the expenses. This may include prescriptions, health insurance premiums, transportation, or doctor visit payments.

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

❑ YES ❑ NO 3. Does anyone <u>besides the people on your case</u> pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? <u>OR</u> 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. Does anyone pay legally obligated child support to someone who is not in the household? If **YES**, give name of person paying, person supported, and amount: _____

_____

BY MY SIGNATURE BELOW, I DECLARE: 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 allow** ❑ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, and the Department for Aging and Rehabilitative Services. I can withdraw this authorization at any time by notifying my eligibility worker.

_____ _____

Signature of Applicant or Authorized Representative **Date**

AGENCY USE ONLY	
Case Name	Case Number
Locality	Date Received
Date of Interview:	❑ In office ❑ Telephone
Interviewer	Program (s)

APPLICATION FOR THE ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP)

FORM NUMBER -

PURPOSE AND USE OF FORM – This application presents only the information needed to determine SNAP eligibility for households containing elderly members only. Applicants may use this application to apply for ESAP. Applicants are not limited to using the ESAP application. Applicants may use any acceptable Virginia SNAP application. The application must be retained for a minimum of three years.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – The local department must evaluate information presented on the application to determine ESAP or SNAP eligibility.

INSTRUCTIONS FOR PREPARATION OF FORM – Applicants must complete the application fully.

Commonwealth of Virginia
Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)

Renewal Application for
Elderly Simplified Application Project (ESAP)

To:

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

Your ESAP eligibility will end on:

Your eligibility for ESAP benefits is expiring. You must file a new application by _____ for uninterrupted benefits, 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 complete the application attached here. The application must have at least your name, address, and your signature. You may file the application:

- in person at the address shown above;
- by mail, fax, by e-mail; or ☜ **Please use only one method to renew.**
- apply online at https://commonhelp.virginia.gov/access/.

In most instances, we will not need an interview to process your renewal application. You may request to have an interview however. If we need an interview or if you request one, we will let you know when and how the interview will occur. We will also let you know if we need additional information.

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.

Eligibility Worker	Date	

USDA Nondiscrimination Statement

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

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

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

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

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW, Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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

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

This institution is an equal opportunity provider.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

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

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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

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Case Number _____
Date Received _____

ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP) RECERTIFICATION APPLICATION

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 at https://commonhelp.virginia.gov/access/.

A. HOUSEHOLD 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

You may receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov). List either a cell telephone number or an email address. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

❑ **Text** ❑ **Email** **Cell Phone Number** _____ **Email Address** _____

B. Household/Unit Members. List everyone who lives with you who.

Name	Date of Birth	Relationship to you

List information for any new people who moved into your home after you last applied for SNAP benefits.

Name:	Name:
Date of Birth: Sex:	Date of Birth: Sex:
Relationship:	Relationship:
*Social Security Number:	*Social Security Number:

*Social Security Numbers are used to check computer systems before new members may be added to the case:

C. Resources. List the balances of any bank accounts, cash, individual retirement accounts, 401K, 403B, money market funds, or similar accounts, etc.

What?	Where?	Amounts

D. Lottery/Gambling Winnings

Has anyone received or expect to receive winnings of $3,750 or more from lottery or gambling? ☐ Yes ☐ No
If YES, please explain and send proof.

E. Unearned Income. List any income received from Social Security, unemployment, pensions, disability, support or similar sources.

Source	Amount	Source	Amount

Is there a new source of income from Social Security, unemployment, pensions, disability, support or a similar source?
☐ Yes ☐ No If YES, please send proof. What is the new source and amount?

F. Earned Income
Has anyone started or stopped a job? ☐ Yes ☐ No If YES, please send proof.
If YES, name of the employer:_____ Amount earned? _____ How often paid? _____

Expenses	
Child support: Is anyone required to pay child support? If YES, what is the amount paid or owed?	
	Enter the monthly amount billed, owed, or paid
Medical (total amount)	
Prescriptions	
Insurance	
Doctor	
Other	
Child/adult Care	
Shelter	
Rent/mortgage	
Utilities	
Taxes/Insurance	
Other	

❑ YES ❑ NO 8. 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_____

❑ YES ❑ NO 9. Have you or anyone for whom you are applying ever been convicted as an adult on or after February 8, 2014 for the following:

m. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO

n. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO

o. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO

p. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

10. You may appoint someone to 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 a representative, please give the information below

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for SNAP benefits❑ Receive correspondence ❑ Access or use SNAP benefits

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:

- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and may 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 I fail to report or verify my expenses, my household will not receive a deduction for the unreported or unverified 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.

_____ _____

Your Signature or Authorized Representative's Signature or Mark Date

_____ _____

Witness to Mark or Interpreter Date

ELDERLY SIMPLIFIED APPLICATION PROJECT (ESAP) RECERTIFILCATION APPLICATION

FORM NUMBER -

PURPOSE AND USE OF FORM – Use of this application is limited to recertification or renewal of ESAP cases. This application may not be used in lieu of an application to apply for initial benefits, or to reapply for benefits after a lapse in certification. Applicants are not limited to using the ESAP recertification application as applicants may use any acceptable Virginia SNAP application. The application must be retained for a minimum of three years.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – The local department must evaluate information presented on the application to determine ESAP or SNAP continued eligibility for elderly households.

INSTRUCTIONS FOR PREPARATION OF FORM – Applicants must complete the application fully.

Virginia Department of Social Services
Division of Benefit Programs
SNAP EBT Replacement Request and Client Attestation

Complete this form for loss due to theft, card skimming, or similar situation and return it to your local department of social services.

Head Of Household:
Last 4 Digits of Social Security Number:
Street Address:
Phone:
Date Of Discovery of Theft:

I, _____attest that I am a member of the household, or an authorized representative, and wish to request replacement SNAP benefits in the amount of $_____to cover the cost of benefits lost due to theft because of skimming, cloning or other similar fraudulent methods that occurred from, ____,20___through ____,20___.

Describe the loss or theft of benefits:

_____

_____

Verification of the loss is required before any benefits can be replaced. The Local Department of Social Services will validate claims of benefit theft though EBT processor data, statements from customers, retailer data, identified skimming devices**,** or other similar information.

PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING THIS FORM
YOUR SIGNATURE IS YOUR ATTESTATION OF LOSS

- ☐ I understand that reports of electronic benefit theft must be reported within 30 calendar days of the discovery of theft through skimming, cloning, or other similar fraudulent methods.
- ☐ I understand that replacement benefits due to theft cannot exceed the amount two months of SNAP benefits or the amount of my actual reported loss, whichever is less.
- ☐ I understand that I must sign and return this statement within 10 business days of the date I reported the household theft to my Local Department of Social Services, or my benefits cannot be replaced.
- ☐ I understand that benefits lost due to theft cannot be replaced more than two times in a federal fiscal year (October 1 through September 30 of each year 10/1/22 – 9/30/24).
- ☐ I understand that benefit replacements for theft can only be claimed from **10/1/2022** through **9/30/2024**.
- ☐ I understand that I will be subject to penalties if I misrepresent the facts including but not limited to a charge of perjury for a false claim.
- ☐ I understand that I have the right to a Fair Hearing if I disagree with the decision to replace benefits made by Local Department of Social Services.

_____

Client Signature *Date*