

## **INSTRUCTIONS FOR REDETERMINATION OF ELIGIBILITY**

The purpose of this form is to collect information we need to determine that you continue to be eligible for help from the Department of Social Services. You may also use this form to apply for new people in your household or to apply for other programs offered by the department.

If you are not currently receiving some type of help from the department, you may not use this form to apply for benefits. Please speak to a worker at your local office to get the correct application form.

Married couples need only complete one redetermination form. Be sure to list the names of both spouses on the first page. Be sure to have both people sign the form.

If you are a nursing home resident with a spouse in the community, provide information about your spouse's income and shelter expenses in the appropriate sections of the form. We will use this to determine how much of your income can be made available to your spouse.

Since we use this form for all programs, there may be some questions that do not apply to you. For example, you do not have to answer any questions on the form that are marked with a star (★) as long as you receive only Food Stamps and are not applying for any other programs.

**Remember to write your worker's name in the space provided at the top of the form and on the return envelope.** This will help to get your form to the right person as quickly as possible. If you do not know who your worker is, you will find his or her name at the top of the enclosed notice. Unless otherwise instructed, be sure to answer all the questions on the form. Answer each question to the best of your ability. If the answer to a question is no, write or check "NO" on the form. If the answer to a question is yes, write or check "YES" and give the details in the space provided. Your answers must be complete and correct so that we may process your redetermination properly. If the information you have does not fit on this form, attach a separate sheet of paper. **IF YOU HAVE ANY QUESTIONS, CALL YOUR WORKER FOR HELP.**

You may have someone else help you complete the form. If someone else does help you, be sure that the helper signs and dates the last page of the form. If you wish to have another person apply for Food Stamps for you or get an EBT card to buy your food, let your worker know.

If you cannot do something we ask you to do because you have a disability, you may request an accommodation or special help. We can use different methods to complete your redetermination. For example, we may be able to complete your redetermination over the telephone if you cannot come into the office, we may be able to help you get certain proofs, or give you extra time to provide information. Let your worker know if you need an accommodation or any special help. If we do not agree to provide an accommodation or special help, you can complain to the department's Americans with Disabilities Act (ADA) coordinator. See the bottom of page 8 for how to make a complaint.

**Be sure that you sign and date the form and bring in or mail it as instructed in the enclosed notice.**

*Deaf and hearing impaired individuals may use a TDD/TTY by calling 1-800-842-4524. Questions, concerns, complaints or requests for information in alternative formats must be directed to the Government and Public Relations Office at 1-800-842-1508.*

## REDETERMINATION VERIFICATION REQUIREMENTS

Certain information that you have given in your Redetermination Eligibility Document may need to be verified. This includes things that may change such as income or assets or new information such as a new job or a new person in your home. The following list will give you an idea of the documents that may be used to prove your statements.

Income - You may provide copies of pay stubs, tax returns or bookkeeping records for self-employed household members, copies of checks from the source of income, a layoff notice or letter, an award letter or a signed statement from the person or source of any income.

Assets - You may use bankbooks, bank statements, trust fund agreements, copies of stocks/bonds/U.S. Savings bonds, life insurance policies, a letter from a financial institution, a copy of a car registration, deeds or legal agreements as proof.

Shelter and Utility Costs - These may be proved by giving your worker your latest rent receipt, a copy of your lease, a copy of your utility bill, a letter from your landlord, a copy of your mortgage bill, a copy of your property tax bill or a copy of your homeowner's insurance.

Medical Insurance and Expenses - Medical insurance policies, medical cards and copies of medical bills may be used to prove these expenses.

Child Support Costs - You may provide a copy of the court order to prove the legal obligation to pay child support and the obligated amount. Acceptable forms of proof of your actual payments include such documents as cancelled checks, wage withholding statements, or a statement from the custodial parent as to the amount you pay in child support or the child support expected to be paid within the certification period.

Students - Acceptable proofs are items such as a signed School Verification Letter (W-1446), a copy of a recent (less than 30 days old) report card or a statement from a school official.

New Household Members - You may use copies of birth certificates, baptismal records or other records documenting birthdates and relationships, marriage and divorce papers, or school attendance verification for children over age 18.

Medical Condition - You may use a statement from a medical provider, hospital or clinic records, or other medical records that are less than 30 days old.

**Please try to bring in or mail the required verifications with the redetermination form as instructed in the enclosed notice.** However, if you do not have all the verifications, please keep your appointment or mail the form in before the deadline with whatever information you do have.

# The Department of Social Services Offers Voter Registration

**The department wants you to have the chance to be active in the political process.**

Congress passed the National Voter Registration Act (NVRA) of 1993 in order to make it easier for you to get and file an application to register to vote. The Department of Social Services can help you register to vote. That is why we ask you to answer the questions on the next page. These questions tell us about whether you are registered to vote. Please complete this form and return it to us with your application form.

If you are not registered to vote, you can apply to register with the department. You need to fill out an application to register. We sent an application to register to you with this application form or your worker gave you a form. If you did not receive an application to register to vote, please tell your worker. Your worker will get a form to you.

## DECLINING TO REGISTER TO VOTE

Connecticut General Statutes Sec. 9-230 states that state offices administering Food Stamps, Medicaid, WIC, Temporary Family Assistance, and offices providing state-funded programs primarily engaged in providing services to persons with disabilities must provide individuals with the opportunity to register to vote. This form must be completed with each application for service or assistance, and with each recertification, renewal, or change of address form relating to such service.

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

Yes       No       I decline because I am already registered

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

Applying to register or declining to register will **not** affect the assistance this agency will provide.

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.

- If you are applying in person, you may fill out the application form in private.
- If you are applying by mail, call your worker. **A notice is included that has your worker's name and telephone number.**

If you fill out and sign the voter registration application, you can:

- leave it with your worker,
- mail it to us in the enclosed envelope or
- mail it directly to the registrar of voters in your Town Hall.

Declining to register to vote and the particular office at which you register to vote remain confidential and will be used only for voter registration purposes.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### For Agency Use Only

Voter Registration Form Completed:     Yes     No     Already Registered

Voter Registration Form given to applicant for later mailing (at applicant's request)

\_\_\_\_\_  
Agency Staff Name

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

\_\_\_\_\_  
Date

(Tear Here and Keep)

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, or your right to choose your own political party or other political preference, you may file a complaint with:

State Elections Enforcement Commission, 20 Trinity Street, Hartford CT 06106,  
Phone: (860) 566-7106; TDD: 1-(800) 842-9710

-FOR WORKER'S USE ONLY-	
EWID	_____
AU #	_____
Redet end date	_____

**REDETERMINATION ELIGIBILITY DOCUMENT**

**Answer the following questions honestly and completely. Please print all answers.**

What is your worker's name? \_\_\_\_\_

Do you need a reasonable accommodation or special help, because of a disability, in order to complete your redetermination?  Yes  No  
What type of special help do you need? \_\_\_\_\_

Are there any other types of help that you need?  Yes  No If Yes, what type(s) of help do you need?  Cash  Medical  Food Stamps

**YOUR NAME AND ADDRESS**

First Name	M.I.	Last Name	Maiden Name	Telephone Number Your # Message #	Client ID Number(s)
------------	------	-----------	-------------	---	---------------------

Where do you live?	Number	Street	Apt. Number	Floor Number	City	State	Zip Code
--------------------	--------	--------	-------------	--------------	------	-------	----------

Where is your mail sent if different from above?	Number	Street	Apt. Number	Floor Number	City	State	Zip Code
--	--------	--------	-------------	--------------	------	-------	----------

**Before you fill out the rest of this form, please read the following instructions. Give us information about yourself where it says self. List all others except people who pay you for room or room and board.**

**HOUSEHOLD MEMBERS – People for whom you are receiving help.**

	Name	Sex (M/F)	Relationship to Head of Household	Date of Birth	Social Security # (optional if you are not applying)	Are you Hispanic or Latino? (Yes/No)	**Racial Origin Code(s)	★ Highest Grade Completed	Name and Address of School, Daycare, etc.	Citizenship/ Immigration Status (optional if you are not applying)
1.	<b>SELF</b>									
2.										
3.										
4.										
5.										
6.										
7.										

\*\*Racial Origin Codes: **A** = Asian **B** = Black or African Descent **C** = White **N** = Native American or Alaska Native  
(Enter a letter for all that apply.) **P** = Native Hawaiian or Other Pacific Islander

★ Has anyone listed been married, divorced, separated or widowed since your last review?  Yes  No Who? \_\_\_\_\_

**HOUSEHOLD MEMBERS (CONTINUED)**

-FOR WORKER'S USE ONLY-

If you are applying for Temporary Family Assistance (TFA), State Administered General Assistance (SAGA) Cash Assistance or Food Stamps, have you or anyone you have listed on the previous page ever been convicted of a felony?  Yes  No If Yes, please answer the following questions about that household member. Is there a current felony charge against you or anyone you have listed?  
 Yes  No

Name \_\_\_\_\_ Are you fleeing from the authorities?  Yes  No If Yes, please explain.

Are you on parole?  Yes  No If Yes, are you in violation of your parole?  Yes  No If Yes, please explain.

Have you been convicted of a drug related felony since 8/22/96?  Yes  No  
 If Yes, have you completed the sentence imposed by the court?  Yes  No  
 Are you complying with your probation requirements?  Yes  No  
 Are you in the process of completing or have you completed participation in a substance abuse treatment or monitoring program?  
 Yes  No If Yes, please explain.

Is there anyone else living with you, other than the people you listed on the previous page?  Yes  No If Yes, provide the following information:

Name	Relationship to you	Does this person:	Amount person pays
1.		<input type="checkbox"/> Share expenses <input type="checkbox"/> Pay for room and meals <input type="checkbox"/> Buy and cook food with you <input type="checkbox"/> Pay for room only	\$ _____ per _____
2.		<input type="checkbox"/> Share expenses <input type="checkbox"/> Pay for room and meals <input type="checkbox"/> Buy and cook food with you <input type="checkbox"/> Pay for room only	\$ _____ per _____

Does anyone listed above wish to apply for help?  Yes  No  
 Name(s) \_\_\_\_\_ What kind of help?  Cash  Medical  Food Stamps

Do you have any new or additional information to report regarding the parent(s) of children not living in your home (e.g. change in address, employer, etc.)?  Yes  No If Yes, please explain.

★ Do you or anyone you have listed expect to receive an inheritance?  Yes  No If Yes, list amount \$ \_\_\_\_\_  
 Who expects to receive this inheritance? \_\_\_\_\_  
 From whose estate will this inheritance be coming? \_\_\_\_\_

★ Are you or anyone you have listed suing anyone? [Include suit(s) due to an accident.]  Yes  No If Yes, provide the following information: person involved, reason for suit, amount of expected settlement, name and address of your attorney.

Since your last review, were you or anyone in your household involved in a work related, automobile, or other type of accident, which required medical attention?  Yes  No If you were, when did the accident occur? Please describe what happened.

**MEDICAL INSURANCE**

-FOR WORKER'S USE ONLY-

Indicate whether you or anyone listed are covered by any of the following insurances. **IMPORTANT – Include information about medical insurance which is provided to child(ren) by an absent parent.**

Insurance Type	Name(s)	Policy/Claim Number	Effective Date	Insurance Company Name(s)	Premium Amount
Medicare Part A – hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medicare Part B – medical? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other medical/hospital insurance such as Blue Cross/Blue Shield, Health Maintenance Organization (HMO) or union coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Long-Term Care Insurance (coverage that will pay specifically for nursing home care, adult day care, assisted living care or home care and is separate insurance from medical/hospital insurance)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

If Yes, is your Long-Term Care policy approved under the Connecticut Partnership for Long-Term Care program (the face page of the policy will indicate whether the policy is approved under the Connecticut Partnership and provides Medicaid Asset Protection)?  Yes  No

If you checked Yes for any insurance other than Medicare, you must complete form W-1685 "Medical Insurance Information".

Have you or anyone you listed received any hospital, doctor, or other medical services since your last review, which have not been paid or which you paid?  Yes  No

Do you or anyone you have listed have any other medical bills for which you are making payment?  Yes  No

Do you have a Medicare Drug Discount Card?  Yes  No If Yes, when did you start participating in the program? \_\_\_\_\_  
 What is the name of the company who issued the card? \_\_\_\_\_

**ASSETS**

**Do you or anyone listed have any of the following assets? Include any asset with your name or the name of anyone you have listed even if the asset is not yours.**

1) Cash on Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	6) Prepaid Funeral Contract	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Bank/Credit Union Accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	7) Motor Vehicles (car, truck, boat, camper, motorcycle, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
*3) Life Insurance Policies/Death Benefits (Include group policies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	8) Real Estate (Include home, land, non-home and out-of-state property)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Annuities/Trust Funds/Limited Partnerships	<input type="checkbox"/> Yes <input type="checkbox"/> No	9) Any other asset not listed	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Stocks/Mutual Funds/Bonds/U.S. Savings Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If you answered Yes to any of the assets above, complete the following:

Name	Type of Asset	Value/Balance	Company Name/Policy or Account Number/Property location/etc.

**Transfer of Assets**

-FOR WORKER'S USE ONLY-

Have you or anyone you have listed sold, traded, given away, or transferred ownership of any motor vehicles, accounts, property of any kind, stocks, bonds, mutual funds or cash since your last review?  Yes  No Have you had assets transferred through the probate court/surrogate courts in state or out of state since your last review?  Yes  No If Yes to either question, what was transferred, sold or given away, to whom, when, and how much money or what was received in return?

Have you or anyone you have listed sold or junked a car since your last review?  Yes  No

**INCOME (Sources of your money)****Employment Income**

**Are you or anyone you have listed employed full-time, part-time or temporarily?**  Yes  No **Is anyone self-employed? For example, does anyone own a business, baby-sit, give home demonstrations, work on construction, sell homemade crafts, clean house, etc.?**  Yes  No **If you answered Yes to either of the above two questions, complete the following section. If a person has more than one job, list each job separately. Include anyone who receives income from a job-training program. If No, list the last job held by each person within the last year.**

1	Name	Gross Pay (pay before deductions) \$ _____ per _____ Pay day: _____	Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly amount \$ _____	Hours Worked per week _____	Date Started	Date Ended
---	------	--	--	--------------------------------	--------------	------------

Employer Name and Address

Reason for Leaving

2	Name	Gross Pay (pay before deductions) \$ _____ per _____ Pay day: _____	Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly amount \$ _____	Hours Worked per week _____	Date Started	Date Ended
---	------	--	--	--------------------------------	--------------	------------

Employer Name and Address

Reason for Leaving

Has anyone quit a job in the last 90 days?  Yes  No If yes, who? \_\_\_\_\_  
Why did they quit? \_\_\_\_\_ Date of last check \_\_\_\_\_

**Other Income**

Check Yes or No to indicate if you or anyone you have listed receive or have applied for money from any of the following sources:

- |  |  |   |  |
|--|--|---|--|
| 1) Child Support and/or Alimony  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6) Other Private Benefits: Maternity/Sick Pay, Pensions, Worker's Compensation, Union Benefits  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2) Social Security Benefits  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7) Other Income: From Stocks, Bonds, Annuities, Rental Property, Roomers, Boarders, Money from Friends or Relatives, Any other source | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3) SSI (Supplemental Security Income)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 4) Unemployment Compensation   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 5) Other Government Benefits (Types are: Railroad Retirement, Educational Loans and Grants, Veterans Benefits, VA Aid and Attendance, Military Allotment, and HUD Subsidy) | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

**Other Income (continued)**

-FOR WORKER'S USE ONLY-

If someone is receiving income from any of the income sources on page 4, complete the following:

Name	Type of Income	Amount Receiving/How Often?	ID/Claim Number(s) (optional if not receiving/applying for assistance)
		\$ _____ per _____	
		\$ _____ per _____	
		\$ _____ per _____	

If someone has applied for income from any of the income sources on page 4, complete the following:

Name	Type of Income	Date of Application or Claim

**Dependent Care**Do you or anyone you have listed pay someone for day care for a child or disabled adult so that you, he or she can work, attend training or look for a job?  Yes  No If Yes, how much do you pay directly from your income? \$ \_\_\_\_\_ per \_\_\_\_\_

Who is day care for? \_\_\_\_\_

Does the State or anyone else pay your day care?  Yes  No If Yes, how much? Amount \$ \_\_\_\_\_**CHILD SUPPORT DEDUCTION – FOOD STAMP PROGRAM**Do you or any other members of your household pay court ordered child support to someone for a child(ren) who is not a member of your household?  Yes  No If Yes, complete the section below.

Name of person who pays support: \_\_\_\_\_

Name and address of the person you send the child support payments to: (If you make payments to a state, list the state and file number.)

Name: \_\_\_\_\_ Which state? \_\_\_\_\_

Address: \_\_\_\_\_ File Number: \_\_\_\_\_

Name and date of birth of the child(ren) for whom you pay this child support:

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____

What is the amount of child support that has been ordered by the court? \$ \_\_\_\_\_ How often is support due? \_\_\_\_\_

How much child support do you **actually** pay each month? \$ \_\_\_\_\_ Do you pay by wage withholding?  Yes  NoHave you been paying child support for three or more months within the last six-month period?  Yes  NoAre your support payments up to date?  Yes  NoAre you making payments to reduce an arrearage (back support)?  Yes  No

If yes, how much do you pay on the arrearage? \$ \_\_\_\_\_ How often do you pay? \_\_\_\_\_

**LIVING ARRANGEMENT AND SHELTER EXPENSES**

-FOR WORKER'S USE ONLY-

Check one of the following boxes which most clearly describes your type of living arrangement:

- Own Home     Share Rent     Homeless     Rent a room (meals included)     Nursing Home  
 Rent     Living with another and not paying rent     Rent a room (meals not included)     Other Medical Facility  
 Other (specify) \_\_\_\_\_     Licensed Boarding Facility

If you checked "Licensed Boarding Facility" or "Other Medical Facility", do not answer the remaining questions A-I in this section.

If you checked "Nursing Home", do you have a spouse in the community?  Yes     No    If Yes, answer questions A, B, C, D, H and I in this section about your spouse's living arrangement and shelter expenses. If No, do not answer the remaining questions in this section.

A. Write in the amounts you are expected to pay each month for the following costs:

Rent \$ \_\_\_\_\_    Mortgage \$ \_\_\_\_\_    Condominium Fees \$ \_\_\_\_\_  
 Taxes \$ \_\_\_\_\_    Insurance \$ \_\_\_\_\_

B. Do you receive any type of rental or housing assistance, such as Section 8, HUD, or State Rental Assistance?

Yes     No    If Yes, enter amount **you pay** to the landlord \$ \_\_\_\_\_.

C. Do you pay for heat?     Yes     NoD. Do you have an air conditioner and pay for electricity?     Yes     NoE. Does your landlord charge you extra for heat or cooling?     Yes     NoF. Did you receive a check from the Energy Assistance Program during the last year at this address?     Yes     No

G. Do you pay for any of the following utilities: electricity, gas for cooking, trash removal, water, sewer, septic maintenance?

Yes     No

H. Do you pay a monthly phone bill (residential or cellular)?     Yes     No

I. If you rent, please give us the following information about your landlord.

Landlord Name	Landlord Address	Telephone Number

**STUDENTS**Are there any students (full-time or part-time) in your household over 18 years of age?     Yes     No    If Yes, complete the following:

Name of Student	School or Program	Expected Date of Graduation

Is the student on a meal plan?     Yes     No    Does the student work?     Yes     No    If yes, number of hours \_\_\_\_\_  
 Does the student receive federal work-study?     Yes     No    Does the student receive educational grants?     Yes     No

**\* SPECIAL EATING ARRANGEMENT**

Complete this section **ONLY** if you are blind, disabled, or over age 65, and are applying for State Supplement or medical assistance.

Do you or anyone you have listed eat at least one meal a day at a restaurant?     Yes     NoDo you or any member have a special diet?     Yes     No    If Yes, why?

## READ CAREFULLY AND SIGN

### FOR ALL PROGRAMS

I understand and agree to the following:

- I will notify the Department of Social Services within 10 days of any change in income, assets or living arrangements unless I receive only Food Stamps, and am a 6-month reporter.
- I may request a hearing in writing if I disagree with an action taken on my case. I may request a hearing by phone or in person if receiving or applying for Food Stamps.
- All information given on this form is subject to verification by federal, state and local officials. I will cooperate with these officials by providing authorizations, documents and other proof to support what I have said. I authorize the Department of Social Services to verify any information given on this form.
- If I make a false or misleading statement, I may be referred for prosecution.
- All information given on this form is confidential and will only be used to administer the programs except for certain exceptions for the Food Stamp, TFA and SAGA programs indicated below.
- The Social Security numbers of all people receiving or requesting assistance will be used to verify identity and eligibility. Social Security numbers also will be cross-matched against federal, state and local government files by computers. The department is allowed to request Social Security numbers based on the following statutes: for Food Stamps, the Food Stamp Act of 1977, 7 USC section 2025(e)(1) and 42 USC sections 1320b-7(a)(1), (b)(4); for TFA, 42 USC sections 1320b-7(a)(1), (b)(1); for Medicaid, 42 USC sections 1320b-7(a)(1), (b)(2); for State Supplement to the Aged, Blind and Disabled, 42 USC sections 1320b-7(a)(1), (b)(5); for SAGA, the Tax Reform Act of 1976, 42 USC section 405(c)(2)(C)(i); for all programs except SAGA, Connecticut General Statutes section 17b-77.
- Information available to the State through the Income and Eligibility Verification System (IEVS) and, for Temporary Family Assistance information from the National Directory of New Hires, will be requested and used to process my redetermination of eligibility. This information will come from the Labor Department, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may be verified directly with other sources such as banks and employers. Results from such verification may affect my household's eligibility and level of benefits.
- I declare that I and the other people for whom I am requesting benefits are either United States citizens or, in the event any of us are not, that the information I have provided regarding anyone's non-citizen status is true.
- I authorize the Department of Social Services to verify any information regarding anyone's non-citizen status with the Bureau of Citizenship and Immigration Services (BCIS). I understand that the department will not share the information given on this form with BCIS. I also understand that BCIS CANNOT use this application to deny admission to the U.S., harm permanent resident status or deport me.
- Information regarding child support payments, made to the State on behalf of your child, may be verified with the Bureau of Child Support Enforcement (BCSE).
- I will cooperate with state and federal personnel in a Quality Control Review.

### FOR FOOD STAMPS

I understand and agree to the following:

- People who quit jobs or cut back on their hours without a reason cannot get Food Stamps. The first time penalty is for three months. It is six months the second time. It is forever the third time they quit a job.
- People who lie about who they are or where they live cannot get Food Stamps for ten years.
- People who do not follow the Food Stamp Employment and Training rules cannot get Food Stamps. The first time it is for three months. It is six months for any additional offenses.
- When people who receive Food Stamps break a program rule on purpose, they cannot get Food Stamps. The first time it is for one year. It is two years the second time. It is forever the third time they break a rule.
- People found guilty of trafficking in Food Stamps of more than \$500 cannot get Food Stamps forever. Trafficking in Food Stamps means selling them instead of using them to buy food for their family.
- People who are found guilty of buying illegal drugs with Food Stamps cannot get Food Stamps for two years.
- People who are fleeing felons or violating parole or probation cannot get Food Stamps for as long as they continue to flee from law enforcement authorities.
- Law enforcement officers can get the name, address, Social Security number and photograph of a person who gets Food Stamps from the department when they think the person is a fleeing felon or violating parole or probation. They can also get this information about a person who may know something about a felony.
- Failure to report or verify your actual household expenses will be seen as a statement that you do not want to receive an allowable deduction for that expense.
- My application/recertification for and receipt of my Food Stamp benefits is a registration for work for myself and all members of my Food Stamp assistance unit who are required to register. I further understand that I and all other members of the Food Stamp assistance unit who are required to do so must participate in Employment Services unless there is good cause not to participate.
- If I am a 6-month reporter, I will notify the Department of Social Services by the 10th day of the month following the month that my total income goes over the limit for my household size, when I move and when I and other members of my household work less than 80 hours per month if we must meet the Food Stamp work requirement.
- People who misuse an Electronic Benefit Transfer (EBT) card may no longer get Food Stamps. They may also be fined up to \$250,000 or sent to jail for up to 20 years or both. Misuse of an EBT card means altering, selling, or trading a card, using someone else's card without permission or exchanging benefits for cash.

