DSS Street Address:
_____
_____

DSS Mailing address:
_____
_____

Case Identifier: _____
Worker: _____
Date Generated: _____
Due Date: _____

Client Name: _____
Mailing Address: _____
_____

North Carolina Department of Health and Human Services
Division of Social Services (DSS)
Food and Nutrition Services (FNS) Notice of Expiration and Recertification Form

Please tell us if you need assistance because you do not speak English or have a disability. Free language assistance and/or other aids and services are available upon request. To receive free interpreter services, call 1-866-719-0141 or call your local DSS office at _____. After the recorded message, you will reach an operator who can provide you with an interpreter. If you have a disability and need communication assistance, call 1-866-719-0141 or Relay Services:711.

Your FNS benefits will stop on _____. You may be able to continue to get FNS benefits after that date if you fill out this form and return it to us no later than_____.

What do I need to do with this form?
You or your authorized representative must complete this entire form, **sign and date the last page**. You have the right to receive an application upon request. If you cannot complete this form you will only need to provide a signature, legible name, and address. Bring, mail to us at the above address, fax _____or complete application online https://epass.nc.gov/CitizenPortal/application.do. Any household that only has Supplemental Security Income (SSI) can apply for recertification at the Social Security office. If you are a resident of an institution and are applying for both Supplemental Security Income (SSI) and FNS benefits prior to leaving the institution, the filing date of the application is the date you leave the institution. If a signed form is incomplete, your FNS worker will contact you to get more information.

You are responsible for providing required verification information. The information on this form and information obtained from other sources may cause your benefits to stop or change.

- Please make sure the address of the local agency shows through the window of the enclosed return envelope.
- **Do not return this form before the first day of** _____.
- Attach verifications for the month of _____.

Information about Social Security Numbers, US Citizenship and Immigration
For everyone that you are applying for, you must provide information about Social Security Numbers (SSNs) and citizenship/immigration status. If you do not want to answer questions about SSNs or citizenship/immigration status, you may choose not to apply. Providing an SSN is required by the Food and Nutrition Act for applicants seeking benefits. We will only use the SSNs you give us to do computer matches and check what you told us with State and Federal Agencies. You must be a United States (U.S.) citizen or an eligible alien and also meet other Food and Nutrition Services rules to get Food and Nutrition Services benefits. We will only contact US Citizenship and Immigration Service (USCIS) to check the immigration status on the household members who give us their immigration documents. If an applicant does not provide this information, they will be ineligible for benefits. By signing this form, it states, under penalty of perjury I have given correct information on the citizenship/alien status of all individuals applied for. Household members must provide their financial information because it is needed to determine eligibility for individuals who are applying. Eligible household members who apply will be able to get benefits even though some people in the household are not applying for benefits. The amount of benefits will depend on the number of people requesting benefits.

A. List everyone who lives with you below. (Attach another sheet if needed)

Name ***(First, Middle Initial, & Last)***	**Relation-ship to You**	**Date of Birth**	**Age/ Sex**	**Applying for Benefits? Yes/No**	***Optional Social Security Number (see below)**	***Optional U.S. Citizen Yes/No (see below)**	***Optional Hispanic or Latino Yes/No (see below)**	****Optional Race (see below)**	**Buy & Cook Together? Yes/No**	*****Lives in a Homeless Shelter or on the Street (Yes/No)**
	Self									

*Social Security Numbers and Citizenship information are not needed for those not applying for benefits. *Giving your ethnicity and race information is voluntary and may be protected by the Privacy Act. Eligibility or level of benefits are not affected if ethnicity or race is not answered. When the information is not provided the agency will collect the information by observation during the interview. Giving this information will help ensure program benefits are distributed without regard to race, color, or national origin (this information is used for statistical purposes only).
**Race Choose one or more numbers that apply and enter above: 1-American Indian/Alaskan Native, 2-Asian, 3-Black/African American, 4-Native Hawaiian/Other Pacific Islander and 5-White

*****These questions may assist in identifying Able-Bodied Adults without Dependents (ABAWD). Please answer these questions about any activity within the last 6 months.**

B. Tell us about your finances.

***1. Does anyone in your household work? ❑Yes ❑ No If yes, complete below.

***2. Is anyone in your household getting ready to start a job? ❑Yes ❑ No If yes, expected start date_____ and complete below.

Attach all income verification pay received during the month listed on Page 1. If you are paid monthly, attach income verification for the month listed on Page 1. If you are self-employed, attach last year's federal tax forms and include all schedules. If tax forms for last year are not available attach your business records and receipts for business expenses for the previous 12 months. If it is new employment, attach verification for all pay received so far.

If you do not have all your check stubs, you may have your employer complete the employer verification section below. (Attach another sheet if needed)

Name of Person Working:			**How Often Paid: (weekly/month, etc.)**		
Employer Name:			**Employer Phone Number:**		
Date Pay Received (month & day)	**Number of Hours**	**Rate of Pay**	**Bonus or Vacation Pay**	**Gross Pay**	**Tips**
Employer Signature:			**Employer Title:**	**Date Signed:**	

***3. Has anyone in your household stopped working within the last 6 months? ❑Yes ❑ No If yes, who stopped working? _____ Reason? _____Date last worked? _____ Date of last pay? _____ Total hours worked in last 30 days? _____

***4. Does anyone in your household get money other than from work? ❑Yes ❑ No If yes, complete below and attach verification for month listed on page 1. Examples: Cash, Contributions, Work First, Child Support, Unemployment Benefits, Social Security, SSI, Worker's Compensation, Veteran's Benefits, etc. (attach another sheet if needed)

Name	**Type of Income**	**Person or Organization That Gives the Money**	**Phone Number and Address of Person or Organization**	**Amount of Income (before taxes)**	**How Often?**

***5. Does anyone work as a volunteer or participate in a work training program? ❑Yes ❑ No If yes, complete below.

Name	**Name of Volunteer Site or Work Training Program**	**Site Address and Phone Number**	**Start Date**	**End Date**	**Hours Per Week**

6. Does anyone own or jointly own any assets including a non-household member(s)? ❑Yes ❑ No If yes, complete below.
We will determine if verification is needed and if it is accessible to you. (Attach another sheet if needed)

Name (Who Owns it?)	**Type of Asset**	**How Much or Value of Asset?**	**Where Do You Keep This Asset and What is the Account Number?**
	Cash on Hand		
	Checking Account		
	Savings Account		
	Lottery/Gambling Winnings		
	Other (such as interest income)		

C. Tell us about your expenses.

❑Yes ❑ No	Do you pay rent or mortgage where you live? If yes, how much do you pay out of your pocket each month? $_____
❑Yes ❑ No	Do you receive assistance paying your rent? If yes, check any you received ❑ HUD ❑ Section 8 ❑ Public Housing
❑ Yes ❑No	Do you pay any other expenses where you live? If yes, check the expense and enter the monthly amount: ❑Lot Rent $_____ ❑Property Taxes (if paid separately) $_____ ❑Other (list type) $ _____ ❑Homeowner's dues (if paid separately) $_____❑Homeowners Insurance (if paid separately) $ _____
❑ Yes ❑No	Are you responsible for paying any utility bills separate from your rent? If yes, check all that apply. ❑ Heat ❑Kerosene ❑Fuel Oil ❑Electricity ❑ Coal ❑ Wood ❑ Natural Gas ❑ LP Gas ❑Telephone/Cell Phone ❑ Water/Sewage ❑Garbage/Trash ❑ Utility Excess (Public Housing) How do you heat your home? _____ How do you cool your home? _____

❑ Yes ❑No	Does anyone help pay your bills? If yes, who helps? _____How much $ _____
❑ Yes ❑No	Did you get a Low-Income Energy Assistance Program (LIEAP) check in another state or at your current residence that was more than $20, in the recent month or within the past 12 months? If yes, who _____
❑Yes ❑No	Is your household responsible for paying any childcare or disabled adult care? If yes, who receives care? _____ Who pays? _____amount per month $ _____ Name and phone number of care provider? _____ Child/adult care expenses? _____
❑ Yes ❑No	Does anyone age 60 or over, or anyone receiving disability benefits, have out-of-pocket medical expenses over $35 monthly? This includes Medicare or Health Insurance and transportation cost for medical care. If yes, do you wish to claim a deduction for these expenses ❑ Yes ❑ No If yes, to get this deduction you must attach receipts or a computer printout of your expenses.
❑ Yes ❑No	Does your household pay court ordered child support for children outside your home (include court ordered health insurance payments)? If yes, who pays the child support? _____ Who is it paid to? _____ Child's name? _____ Amount you pay? $_____ How often? _____

D. Tell us about the people in your home.

❑Yes ❑ No	Is anyone in your household age 16 or older attending school at least half time now or have they in the last 6 months? If yes, list the person's name and school they attend: _____
❑Yes ❑ No	Does anyone in your household have a felony drug conviction or controlled substance after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction: _____ _____
❑ Yes ❑No	Is anyone in your household in violation of probation or parole or running from the law to avoid felony prosecution? If yes tell us his/her name, date, type, and place of conviction: _____ _____
❑ Yes ❑No	Have you or any member of your household been convicted as an adult of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense, after February 7, 2014? If yes tell us his/her name, date, type, and place of conviction: _____
❑ Yes ❑No	Have you or any member of your household been convicted of trading benefits for drugs after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:_____ _____
❑Yes ❑No	Have you or any member of your household been convicted of buying or selling benefits $500 or more after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction_____ _____
❑ Yes ❑ No	Have you or any member of your household been convicted of fraudulently receiving duplicate benefits in any State after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction: _____ _____
❑ Yes ❑ No	Have you or any member of your household been convicted of trading benefits for guns, ammunitions, or explosives after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction: _____ _____
❑Yes ❑No	Is anyone in your household physically or mentally unfit for employment? If yes, who and what months? _____
❑ Yes ❑ No	Does anyone operate a Home School at least 30 hours a week? If yes, who and what months? _____
❑Yes ❑ No	Does anyone care for an incapacitated person (does not have to live in the home)? If yes, who and what months? _____
❑ Yes ❑ No	Does anyone participate in an official Refugee Employment Program? If yes, who and what months? _____
❑ Yes ❑ No	Is anyone in the household unable to work due to alcohol and/or drug addiction? If yes, who and what months? _____
❑Yes ❑ No	Is anyone in a drug or alcohol treatment program? If yes, who and what months? _____
❑Yes ❑ No	Is anyone in the household pregnant? If yes, who? _____

Authorized Representative

Do you need someone to help you get and/or use your Food and Nutrition Services benefits? ❑ Yes ❑ No If yes, please list that person's name _____. If you checked **Yes** above, we will give or mail you a form. You and the person you want to help can complete the form and return it to our office. This person will receive an EBT card and will have access to your Food and Nutrition Services Benefits. If you already have an authorized representative, do you want them to continue?
❑ Yes ❑ No Authorized Representative Name: _____

How to Get a Fair Hearing

You have the right to ask for a hearing in person, by telephone or in writing, if you think your case is wrong. You have 90 calendar days to ask for a hearing. Unless you ask for a hearing by then, you cannot have one. A household member or someone else such as a lawyer, friend, or relative can represent you at a fair hearing. Free legal advice may be available. Contact Legal Aid of North Carolina office at 1-866-219-5262, Street: 224 South Dawson St. Raleigh, NC 27601, Mailing: PO Box 26087 Raleigh, NC 27611.

Voter Registration

"If you are not registered to vote where you live now, would you like to apply to register to vote here today?
❑ **Yes** ❑ **No**

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. Register to vote in North Carolina. If you want to register to vote or to update your registration, you can complete a voter registration form at www.ncsbe.gov/nvra/01, ask your caseworker or contact your local DSS for a voter registration form. **Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.** If you would like help in 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 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 the North Carolina State Board of Elections, PO Box 27255, Raleigh NC 27611-7255, or you may call the toll free number, 1-866-522-4723."

You Will Not Be Discriminated Against

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: https:// www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-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:
mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
fax: (202) 690-7442; or
email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Getting Help with Your Telephone Bill

If you receive Supplemental Security Income (SSI), Food and Nutrition Services, Medicaid, Federal Public Housing (Sec. 8 Housing Assistance), or Veterans Pension and Survivors Benefit you may be eligible for a local telephone service discount. Lifeline provides recipients a discount on monthly telephone service purchased from participating providers. Recipients can also purchase discounted broadband from participating providers. Discounts will apply to stand-alone broadband, bundled voice-broadband packages, either fixed or mobile and stand-alone voice service. The Link-Up Program allows recipients who are Native Americans residing on federally recognized tribal lands a discount toward the cost of connecting local telephone service. Households interested in these services must contact their telephone company to apply.

Your Signature and Statement of Understanding

I understand that my signature authorizes federal, state, and local officials to contact other persons or organizations to verify the information I have provided. Do not lie or hide information to get benefits that your household should not get. I have given correct information on the citizenship/immigration status of all individuals applied for. If a law enforcement officer requests the address, social security numbers, or photographs in your file to assist in locating fugitive felons or probation/parole violators, the agency must provide this information. I will report lottery and/or gambling winnings in the amount of $3,750 or more. I am aware all household members will lose eligibility to receive Food and Nutrition Services.

Any member who intentionally breaks any of the rules, may not be able to get Food and Nutrition Services for one year for the first violation, two years for second the violation, and permanently for third the violation. If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first violation, and permanently for the second violation. You may also be fined up to $250,000 and/or jailed up to 20 years. If court ordered, you may also be ineligible from the Food and Nutrition Services program for an additional 18 months. If a court finds you guilty of having trafficked benefits for $500 or more, or trading benefits for firearms, ammunition or explosives you will be permanently ineligible for Food and Nutrition Services. If you use your food assistance benefits to buy nonfood items, trade, or sell your benefits, pay on credit accounts, take someone's EBT card without authorization or let someone use yours, you will lose your benefits. If you give false information about your identity or residence in order to get Food and Nutrition Services in more than one place, you will not get Food and Nutrition Services for 10 years. If you have a Food and Nutrition Services claim arise against you, we will give your answers and Social Security Numbers to federal and state agencies, as well as private claims collection agencies, to collect the overpayment. All eligibility procedures are strictly supported by the Food and Nutrition Services policies. The other programs time limits or requirements do not affect your Food and Nutrition Services benefits. Your household may not be denied food assistance because your household has been denied benefits from other programs.

I acknowledge that I have received an explanation of my right to an income deduction for Food and Nutrition Services benefits for any of the following items: Child/adult care expenses, medical expenses, shelter expenses, utility expenses, and operational expenses for self-employment. I understand that if I fail to report or verify any of the above listed expenses, I will give up my right to receive a deduction for these expense(s).

YOU MUST SIGN AND FILL OUT THE INFORMATION BELOW BEFORE RETURNING

Your Signature or Authorized Representative _____Date Signed _____

Witness Signature (if signature is an X) _____Date Signed _____

First Name _____Middle Initial_____ Last Name_____

Residence Address (House/Apt. #, Street)
_____City_____ State_____ Zip Code _____

Mailing Address (if different from Residence Address)
_____ City_____ State_____ Zip Code _____

Home Phone _____Cell Phone _____ Message Number_____

Telephone Company Provider _____ Language you speak _____

For information regarding the Teen Pregnancy Prevention Initiative contact your local Health Department or call the DHHS Customer Service Center at 1-800-662-7030. For information regarding services provided for Healthy Marriages contact your local agency.

****AGENCY USE ONLY ****

Caseworker Signature_____ Date of Interview_____ ☐ Telephone ☐ Office Visit