

DSS Street Address:

Case Identifier:  
Worker:  
Date Generated:  
Due Date:

DSS Mailing address:

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 Interview Recertification Form**

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 applying for Food and Nutrition Services (FNS) and SSI at the same time from an Institution, the filing date is the date you are released from 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.**

**YOU MUST BE INTERVIEWED. BENEFITS WILL NOT BE ISSUED WITHOUT AN INTERVIEW.** Your caseworker will schedule your interview appointment. Failure to attend an interview may result in denial or delay of benefits. You are responsible for rescheduling a missed interview.

If you have questions or need help completing this form, call \_\_\_\_\_ or call the DHHS Customer Services Center at 1-800-662-7030 or 1-877-452-2514 (TTY Dedicated).

- An interpreter can be provided, free of charge, if you need assistance in applying.
- 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**

You can choose not to apply for benefits for yourself or members of your household and are not required to answer questions about Social Security Numbers (SSNs) and citizenship/immigration information for those you choose not to apply for. For each individual that you are applying for, you must provide information about SSNs and citizenship/immigration status. Providing a 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<br>(First, Middle Initial,<br>& Last) | Relation<br>-ship to<br>You | Date<br>of<br>Birth | Age/<br>Sex | **Lives in a<br>Homeless<br>Shelter or<br>on the<br>Street<br>(Yes/No) | Applying<br>for<br>Benefits?<br>Yes/No | *Optional<br>Social<br>Security<br>Number | *Optional<br>U.S.<br>Citizen<br>Yes/No | *Optional<br>Hispanic<br>or Latino<br>Yes/No | *Optional<br>Race | Buy &<br>Cook<br>Together?<br>Yes/No |
|--|-----------------------------|---------------------|-------------|--|--|---|--|--|-------------------|--------------------------------------|
|  | Self                        |                     |             |  |  |   |  |  |                   |                                      |
|  |                             |                     |             |  |  |   |  |  |                   |                                      |
|  |                             |                     |             |  |  |   |  |  |                   |                                      |
|  |                             |                     |             |  |  |   |  |  |                   |                                      |
|  |                             |                     |             |  |  |   |  |  |                   |                                      |

\*Social Security Numbers and Citizenship information are not needed for those not applying for benefits.

\*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)**

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

\*\*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  |                             |  |
|                     | Other            |                             |  |

**C. Tell us about your expenses.**

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

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does anyone help pay your bills? If yes, who helps? _____ how much? \$ _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Did you get a Low Income Energy Assistance Program (LIEAP) check at your current residence within the past 12 months?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is your household responsible for paying any child care 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? _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to get this deduction you must attach receipts or a computer printout of your expenses. |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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.**

|  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:                               |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:               |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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: |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is anyone in your household physically or mentally unfit for employment? If yes, who and what months?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does anyone operate a Home School at least 30 hours a week? If yes, who and what months?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does anyone care for an incapacitated person (does not have to live in the home)? If yes, who and what months?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does anyone participate in an official Refugee Employment Program? If yes, who and what months?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is anyone in the household unable to work due to alcohol and/or drug addiction? If yes, who and what months?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is anyone in a drug or alcohol treatment program? If yes, who and what months?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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.

**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.

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.

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).

**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.**

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 Bipartisan State Board of Elections and Ethics Enforcement. If you require assistance with voter registration, you can call the North Carolina Bipartisan State Board of Elections and Ethics Enforcement at 1-866-522-4723.

Your Signature or Authorized Representative \_\_\_\_\_ Date Signed \_\_\_\_\_  
Witness Signature (if signature is an X) \_\_\_\_\_ Date Signed \_\_\_\_\_

|                                       |            |                |                            |       |                    |
|---------------------------------------|------------|----------------|----------------------------|-------|--------------------|
| First Name                            |            | Middle Initial | Last Name                  |       |                    |
| Residence Address                     |            |                | City                       | State | Zip Code           |
| (If different from residence address) |            |                |                            |       |                    |
| Mailing Address                       |            |                | City                       | State | Zip Code           |
| Home Phone                            | Cell Phone | Message Number | Telephone Company Provider |       | Language you speak |

**\*\*AGENCY USE ONLY\*\***

Required Caseworker Signature \_\_\_\_\_ Date of Interview \_\_\_\_\_  Telephone  Office visit

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.