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

Co. #	Worker Name	Worker #	Case #	FSIS #	Date Mailed

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

(Local DSS Address) (Household Address)

What Do I Need To Do With This Form?

- When you get this form, fill out, bring, mail, or fax to us at the above address. Please answer all questions completely. **Please sign and date the last page of this form**. **You must return both pages of this form. You are responsible for providing required verification information.**
- If you need help completing this form, call _____ or call the CARE-LINE at 1-800-662-7030.
- Please make sure the address of the local Department of Social Services 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 Shown In Your Food and Nutrition Services Case

We have listed below the information currently shown in your case at the Department of Social Services. This verified information was used to determine your eligibility for FNS benefits.

Household Members:

Your telephone number:

Household Income:

$ Earned Income

$ SSI/PA

$ SS Income

$ Other

Total Number of People Living in your Home:

Main Type of Heat:

Shelter Expenses:

$ Rent/Mortgage

Other Deductions:

$ Dependent Care

$ Legally Obligated Support

Other Shelter Expenses:

$ Utility Allowance

$ Property Tax

$ Household Insurance

Monthly Medical Expenses:

$

Countable Assets: (Resources)

$

Authorized Representative who has an EBT card:

Based on this information, you were eligible for $_____ in FNS benefits. We will use the new information you provide on the attached pages to determine if you continue to be eligible for FNS benefits.

Please Tell Us About Your Household Bills

1. List your mailing and residence address. **If you have moved to a new county do not complete this form. You will need to apply in the new county.**

Mailing Address	**Residence Address**
City, State, Zip Code	**City, State, Zip Code**
Telephone Number	**Telephone Company Provider**

PROVIDE PROOF OF ANY NEW OR CHANGED BILLS SINCE YOUR LAST RECERTIFICATION

2. How much do you pay for rent where you live? $_____ How often paid? _____
   Circle any that you receive: HUD Section 8 Public Housing What is your portion of the rent? _____
   How much do you pay for lot rent where you live? $_____ How often paid? _____

3. How much do you pay for your home mortgage? $_____ How often paid? _____
   Property Taxes: (if paid separately) Amount paid? $_____ How often paid? _____
   Homeowners Insurance: (if paid separately) Amount paid? $_____ How often?_____
   Homeowners Dues: (if paid separately) $_____ How often?_____

4. What utility bills are you responsible for paying? (Check all that apply).

❑ **Heat**	❑ **Kerosene**	❑ **Water/Sewage**	❑ **Coal**
❑ **Electricity**	❑ **LP Gas**	❑ **Telephone/Cell Phone**	❑ **Fuel Oil**
❑ **Garbage/Trash**	❑ **Natural Gas**	❑ **Utility Excess (Public Housing)**	❑ **Wood**

   How do you heat your home? _____ How do you cool your home? _____

5. Does anyone help pay your bills? ❑ **Yes** ❑ **No** If yes, who helps?_____

6. Did you get a Low Income Energy Assistance Program (LIEAP) check at your current residence within the past 12 months? ❑ **Yes** ❑ **No**

7. Is your household responsible for paying any child or disabled adult care? ❑ **Yes** ❑ **No**
   Who receives the care? _____
   Who pays? _____Amount per month or parent fee $_____
   Name and phone number of care provider/babysitter _____
   Child/adult care transportation expenses $_____

8. Does any person **age 60 or over, or anyone receiving disability benefits**, have out-of-pocket medical expenses over $35 monthly**?** This includes transportation cost for medical care. ❑ **Yes** ❑ **No** If yes, do you wish to claim a deduction for these expenses? ❑ **Yes** ❑ **No**
   To get this deduction you must attach receipts or a computer printout of your expenses.

9. Does your household pay court ordered child support for children outside your home (include court ordered health insurance payments)? ❑ **Yes** ❑ **No**
   Who pays child support? _____ Who is it paid to? _____
   Child's Name? _____ Amount you pay $_____How often? _____

Tell Us About the People Who Live With you

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

Name	U.S. Citizen? (Yes/No)	Social Security Number (If the person has one)	Relationship	Date of Birth	Buy & Cook Together?
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

What Money Do People In Your Household Get From Work or Other Places?

11. Does anyone in your household work? ❑ **Yes** ❑ **No** If yes, complete below.
Is anyone in your household getting ready to start a job? ❑ **Yes** ❑ **No** If yes, enter expected start date _____ and complete below.
Name of person _____ Employer _____ How often paid? _____
Name of person _____ Employer _____ How often paid? _____

Attach all check stubs for the month listed on Page 1. If you are paid monthly or self employed, attach check stubs or income verification for the month listed on Page 1 and the month before that month.

If you do not have all your check stubs, you may have your employer complete and sign the section below.

A - Name of Person Working:							**B - Name of Person Working:**						
Employer:							**Employer:**						
Address:							**Address:**						
Employer Phone #:							**Employer Phone #:**						
How often paid?							**How often paid?**						
	Date Pay Received			**Gross Pay**	**Tips**	**Total Hours**		**Date Pay Received**			**Gross Pay**	**Tips**	**Total Hours**
	Mo	Day	Yr					Mo	Day	Yr			
1							**1**						
2							**2**						
3							**3**						
4							**4**						
5							**5**						
_____							_____						
EMPLOYER SIGNATURE **DATE**							**EMPLOYER SIGNATURE** **DATE**						

12. Does anyone in your household get money other than from work? Examples: Cash, Contributions, Work First, Child Support, Unemployment Benefits, Social Security, SSI, Worker's Compensation, VA, etc. ❑ **Yes** ❑ **No**
If yes, attach verification for the month listed on **Page 1**. Please enter the information in the chart below.

If you receive Cash, Contributions, or Child Support, attach verification for the month listed on **Page 1** and the month before that month. (Attach another sheet if needed)

Type of Money	Who Gets the Money?	Who Gives the Money?	Phone Number and Address of person who gives you money	How Much?	How Often?

What Assets Do People In Your Household Have?

13. Check yes or no to assets listed below. (Attach another sheet if needed)

Type of Asset	Yes	No	Balance Or Value	Who Owns It?	Where do you keep this asset and what is the account number?
Cash on Hand					
Checking Account					
Savings Account					
Other					

Please Tell Us More About The People In Your Food and Nutrition Services Household

14. Do you know of anything that has changed in your household such as anyone stopping or starting work or school within the last 6 months? ❑ **Yes** ❑ **No** If yes, please list the changes:

    _____

15. Is anyone in your household age 16 or older and attending school? ❑ **Yes** ❑ **No** If yes, list persons name and school they attend:

    _____

16. Does anyone in your household have a felony drug conviction after August 22, 1996? ❑ **Yes** ❑ **No** If yes, please tell us his/her name, date, type, and place of conviction:

    _____

17. Is anyone in your household in violation of probation or parole or running from the law to avoid felony prosecution? ❑ **Yes** ❑ **No** If yes, please tell us his/her name and the date and type of violation:

    _____

Do You Need Someone To Apply for or Use Your Food and Nutrition Services Benefits for You?

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 there is an authorized representative listed on page 1 do you want them to continue? ❑ **Yes** ❑ **No**

Your Signature and Statement of Understanding

To apply for FNS benefits, you or your authorized representative must complete this form and sign your name on the signature line. If this form is incomplete, your FNS worker will contact you to get more information. If you have any questions, please contact your caseworker or the CARE-LINE at 1-800-662-7030.

Please read the enclosed Rights and Responsibilities.

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: Legally obligated child support, 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 give up my right to receive a deduction for these expense(s).

IF YOU HAVE MOVED TO A NEW COUNTY DO NOT COMPLETE THIS FORM YOU WILL NEED TO APPLY IN THE NEW COUNTY.

I understand that my signature authorizes federal, state, and local officials to contact other persons or organizations to verify the information I have provided.

Your Signature:	**Date Signed:**
Authorized Representative or Witness Signature (if applicable):	**Date Signed:**
Your Telephone Number: _____ Check which applies: ☐ Home ☐ Cell Phone ☐ Work ☐ Message Number	

For information regarding the Teen Pregnancy Prevention Initiative contact your local Health Department or call the CARELINE at 1-800-662-7030. For information regarding services provided for Healthy Marriages contact your local County Department of Social Services.

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

Date of Interview _____ ☐ **Telephone** ☐ **Office Visit**