



FOOD STAMP RE-EVALUATION

TO COMPLETE THE RE-EVALUATION PROCESS for Food Assistance, fill out all pages, sign page 4, and mail your completed application to the Health and Welfare office address listed on your notification letter. If you need to provide more information than space allows, attach extra sheets. You will be interviewed and be required to give us proof to support the information on your application before we can make a decision about your benefits. Please contact your local office if you cannot participate in an interview during normal office hours or if you need interpreter services. **Mail this completed application within ten (10) days of receipt.**

IMPORTANT NOTICE: If you need any of the following types of assistance, please ask. These services are free:

- Help filling out this form.
- Accommodation for a disability.
- Do you want an interpreter when you are interviewed? One will be provided at no cost to you.

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún coste para usted.

Language Interpreter – (Nosotros proveemos los servicios de un intérprete, sin costo alguno.)

Call 2-1-1 or 1-800-926-2588 or TDD 205-332-7205

- What is your preferred language? Spoken: _____ Written: _____

1. Name and address:					
YOUR NAME		SOCIAL SECURITY #		YOUR CASE # (if known)	
HOME ADDRESS:			MAILING ADDRESS (if different):		
APARTMENT NUMBER (IF ANY)			APARTMENT NUMBER (IF ANY)		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
Phone Number where you can be reached (Do NOT leave blank): Primary Number: _____ Alternate Number: _____			BEST TIME TO CALL _____ <input type="checkbox"/> AM <input type="checkbox"/> PM BEST DAY TO CALL: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday		
Email address: _____					
2. List all of the residents in my home (including newborns). Check the box for those residents requesting aid.					
NAME(S)	RELATIONSHIP	Date of Birth	US Citizen?	Social Security #	Alien ID#
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N		
Does anyone in your home have a disability? <input type="checkbox"/> No <input type="checkbox"/> Yes - Who? _____					
Has anyone in your home received or applied for Social Security? <input type="checkbox"/> No <input type="checkbox"/> Yes - Who? _____					
Is anyone in your home a fleeing felon or currently violating conditions of probation or parole? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Who? _____					
For Office Use Only					
AABD #: _____		FM #: _____		ICCP # _____	

Do you have any students in your home? List any household member age 16 or older who is a student or planning to attend school.

Student Name	Name of School	Student Status	Expected Graduation Date
		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	

3. My household's resources.

List everyone in your home who has a checking or savings account:

Owner's Name	Type of Account	Name of Bank/Institution	Account Number	Balance

List everyone in your home who has assets such as stocks, bonds, mutual funds, IRAs, trusts, etc.:

Owner's Name	Type of Account	Name of Bank/Institution	Account Number	\$ Value

List each car, truck, motorcycle, trailer, boat, snowmobile, and other recreational vehicles owned by anyone in your home:

Year	Make	Model

Other than the home you live in, what other resources, such as land or property, do you have and what is their value? (list all):

4. My household's income. Please list all money received and/or expected by all household members. Include all income from wages from a job or self-employment, unemployment benefits, Social Security, SSI, Child Support, tips, student financial aid, veterans benefits (VA), gifts or cash loans.

Type of Money Received	Who Earned/ Received Money?	Name of Employer	How Often Paid?	\$ Per Hour	Hrs per Week	Total Monthly Amount
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Other			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Other			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Other			

Is anyone in your home self-employed? Yes No - If yes, Who? _____

Examples of self-employment are independent contractors, baby-sitters, day care providers or home-owned businesses.

5. My monthly household shelter costs. Check all that apply.

<input type="checkbox"/> Rent: \$ _____	<input type="checkbox"/> Mortgage: \$ _____	<input type="checkbox"/> Property Taxes: \$ _____
<input type="checkbox"/> Space Rent: \$ _____	<input type="checkbox"/> 2 nd Mortgage: \$ _____	<input type="checkbox"/> Home Insurance: \$ _____
<input type="checkbox"/> Association Fees: \$ _____		<input type="checkbox"/> Irrigation Taxes: \$ _____

Mark the utilities you pay that are **NOT** included in your rent or mortgage payments:

Heating Cooling Electricity Gas/Propane Water/Sewer/Trash

If you qualify for Food Stamps, you may also qualify for The **Idaho Telephone Service Assistance Program (ITSAP)**. ITSAP helps pay telephone installation and monthly telephone service costs for low-income households. Do you want telephone assistance for your household? No Yes

If Yes, what phone company do you use? _____ Please attach a copy of your last phone bill.

6. My household expenses. Check all that apply.

My child care costs for (Name of Child) _____ are \$ _____ per month.
Expenses are due to: Work School Work Search

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Expenses are due to: Work School Work Search

I pay for someone to take care of an elderly or disabled person who lives in my home. \$ _____ per month.

Someone in my household pays child support payments of \$ _____ per month.
Who pays child support? _____

If you or someone in you home is 60 or older, blind or disabled, list your monthly out-of-pocket medical expenses (Check all that apply):

<input type="checkbox"/> Medicare: \$ _____	<input type="checkbox"/> Doctor: \$ _____	<input type="checkbox"/> Dental: \$ _____
<input type="checkbox"/> Health Insurance: \$ _____	<input type="checkbox"/> Hospital: \$ _____	<input type="checkbox"/> Prescriptions: \$ _____
<input type="checkbox"/> Work Expenses: \$ _____	<input type="checkbox"/> Service Animal: \$ _____	<input type="checkbox"/> Medical Supplies: \$ _____
<input type="checkbox"/> Attendant Care: \$ _____	<input type="checkbox"/> Transportation/Lodging: \$ _____	<input type="checkbox"/> Eye Glasses: \$ _____

If you have any children in your home, do any of them have a parent NOT living with them? No Yes

If you answered "Yes," you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. See "Child Support Cooperation" on page 4 for more information. Name of Absent Parent(s) _____

7. Personal/Authorized Representative.

You may authorize someone else to apply for benefits for you and use your Food Stamp benefits to buy food for you. To do so, enter their name, phone and address below. NOTE: If your authorized representative gives incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

Name of Authorized Representative:		Phone Number:	
Address	City	State	Zip

Signature of Authorized Representative/Guardian:

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS:

• USDA, Director, Office of Civil Rights – 1400 Independence Avenue, SW Washington, DC 20250-9410 (800) 795.3272 Voice or (202) 720.6382 (TTY)

• U.S. Dept. of Health & Human **Services** – Room 506 F, 200 Independence Ave. SW Washington, D.C. 20210 ocrcomplain@hhs.gov or (202) 619.0403 (Voice) or (202) 619.3257 (TTY)

You may need to provide the following proof:

- Identity
- Student status (full- or part-time)
- Social Security Number or proof that you have applied for one
- Resident Alien Card (if not a U.S. citizen) or other residency documents
- Income or any other money coming back into your household, such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.)
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts
- Expenses (proof of these expenses may increase your food stamp amount) such as child or adult care costs, child support paid to someone not living with you, housing costs, medical expenses (including prescriptions) for people with disabilities or who are over 60, and utility costs. NOTE: Failure to report or verify any of the above listed expenses will mean that you do not want a deduction for the unreported or unverified expenses.

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND THAT.....

- I could be sanctioned and required to return any benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.
- I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.
- I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.
- I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- My signature certifies that the Citizenship / Immigration status that I marked on Page 1 is correct for each person applying for Food Stamps Assistance.
- By applying for benefits for a minor child, a child support case must be opened when applicable. To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease of benefits.
- I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. Your benefits may be ended if you do not cooperate.
- **Child Support Cooperation:** By applying for benefits for a minor child, I may be referred to Child Support Services. If my household includes minor children and one or both parents are not living in the home, I will be required to cooperate with Child Support Services to avoid a loss or decrease of my benefits, unless I fear harm to myself or my children. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in loss or decrease of my benefits.

<i>Under penalty of perjury, I swear or affirm that the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.</i>	
SIGNATURE	DATE
SIGNATURE OF OTHER ADULT HOUSEHOLD MEMBER OR REPRESENTATIVE	DATE