

Idaho Department of Health and Welfare

Date
Worker Name
Case Name
Case Number

DEPT H & W-TVPC
DEPT H & W-TVPC
BOISE, ID 83720-0003
PO BOX 83720

Client Name
Street Address
Boise, Idaho 83201

DEPT H & W - TVPC
PO BOX 83720
BOISE, ID 83720-0003

FOOD STAMP NOTICE ~ 6 MONTH REPORT

According to our records your Food Stamp benefits are due to expire on (last day of cert period, example: November 30).

If you want to continue receiving Food Stamps please complete the steps below by (the 15th of the month prior to cert end month, example October 15).

You do not have to visit our office or call us.



1 *Fill out and sign* the form attached with this letter



2 *Attach proof of* All money your household receives

- Wage stubs for the most recent 4 weeks
- Work verification if this is a new job
- Proof of any other income that is not earned

What your household pays for

- Child Support if you pay it to someone in another state
- Child Care while you work or go to school
- Medical Expenses if you are disabled or over 60

Things you own

- Most recent bank statements
- If you are making payments for your car we need proof of how much you owe
- Proof of the value of any stocks, bonds or property you own.
- Certificates of Deposit



3 *Return the form* by mail, fax or in person, to your local Health & Welfare office

If you are eligible, but complete the above actions after the 15th of next month, your Food Stamps will be late.

Your Food Stamps will close (last day of cert period, example: November 30) if you do not complete all 3 of the above steps

6 Month Report Form

IMPORTANT NOTICE: If you need any assistance, please ask. The following services are free:

- **Help filling out this form**
- **Accommodation for a disability**
- **Language Interpreter. Call 1-800-926-2588 or TDD 208-332-7205**

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with the Department action. You have only 90 days to ask for a hearing for Food Stamps. The 90 days starts the day after the Department gave or mailed you the notice of decision.

If you believe you have been discriminated against on the basis of age, color, disability, national origin, gender, religion, race or political belief, you can file a complaint at your local Health and Welfare office or at either of the offices listed below:

USDA,
 Director, Office of Civil Rights
 1400 Independence Ave., SW
 Washington, D.C. 20250-9410
 (800) 795-3272 (Voice)
 (202) 720-6382 (TTY)

U.S Dept of Health & Human Services
 Director, Office of Civil Rights
 Room 506 F, 200 Independence Ave., SW
 Washington, D.C. 20201
 (800) 795-3272 (Voice)
 (202) 720-6382 (TTY)

Rules: These rules apply. You may review them at your local welfare office 16.05.03



Where do you live?

Daytime Phone Number _____

Street Address	City	County	State	Zip Code
_____	_____	_____	_____	_____
Mailing Address _____				

**Note: Social Security Numbers are required for household members who are applying for Food Stamps benefits.*



Who lives in your home?

(Attach an extra sheet of paper if necessary)

Name	Relationship to you	Date of Birth	What state were they born in?	U.S. Citizen	Social Security or Alien ID Number
_____	SELF	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



Students

List any household member age 16 or older who is a student or who is planning to attend school

Name of student	Name of school	How many hours per week spent in class	Expected Graduation Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



How Much Do You Pay? Attach Proof

How much do you pay for child care while you work or go to school? Name of child _____ paid per month _____

Name of child _____ paid per month _____ Name of child _____ paid per month _____

How much do you pay to take care of an elderly or disabled person who lives in your home? _____ per month

Does anyone in your household pay child support to someone else? Who pays it? _____ paid per month? _____

Is there someone in your home who is disabled or over 60 years old and pays medical expense? How much per month?

Medicare \$ _____ Doctor \$ _____ Dental \$ _____ Health Insurance \$ _____

Hospital \$ _____ Prescriptions \$ _____ Eyeglasses \$ _____ Medical Supplies \$ _____

Service Animal \$ _____ Attendant Care \$ _____ Work Expense \$ _____ Transportation/Lodging \$ _____

How much is your rent or mortgage? _____ per month

Do you have any other shelter costs?

Irrigation \$ _____ per _____ Property Tax \$ _____ per _____ Homeowners Insurance \$ _____ per _____ HOA Fees \$ _____ per _____

Space rent \$ _____ per _____ Second Mortgage \$ _____ per _____

Which utilities do you pay that are not included in your rent?

Heat Air Conditioning Electricity Gas Phone Water/Sewer/Trash

Landlord's Name: _____ Landlord's contact number: _____

Things You Own Attach Proof

List everyone in your household who has a savings account, stocks, bonds, mutual funds, trusts, checking accounts, CD's, burial funds, property (home, land, etc.)

Who owns it?	What do they own? (type of account)	Name of Bank or Organization	Account Number	Balance or Value
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does anyone in your household own any Cars/Motorcycles/4 Wheelers/Campers/RV's/Snowmobiles?

Who owns it?	What do they own?	How much do they owe on it?	Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

New Income or Income That Has Stopped Attach Proof

Name of person with income	Employer or other source of income	Employers Phone number	Did income start or stop?	Date Started	Date Stopped
_____	_____	_____	<input type="checkbox"/> Start <input type="checkbox"/> Stop	_____	_____
_____	_____	_____	<input type="checkbox"/> Start <input type="checkbox"/> Stop	_____	_____
_____	_____	_____	<input type="checkbox"/> Start <input type="checkbox"/> Stop	_____	_____

Income

List all income for everyone in your household. We want to know about the most recent 4 weeks and any money quarterly or annually (once a year). Income is money that is **earned** from a job or self employment and **unearned** such as Social Security, unemployment, Workers Compensation, gifts, rental income and retirement

Attach Proof

Name of person with income	Source of Income	Employer Phone Number	How often paid or received	If employed, hours worked per week	Hourly Pay
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



Do you want telephone assistance for your household? YES NO

If Yes, what phone company do you use? _____

6 Month Report Checklist

Please make sure you:

- Answered all the questions on the form
- Attached proof of all income and expenses (check stubs, tax returns for self employment, child support received and/or paid to someone else, child care cost, medical expenses, etc)
- Sign and date the Rights and Responsibilities page
- Return or mail all documents to the Department

Failure to complete all the steps could cause your benefits to be late or close.



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 in Section 1 is correct for each person applying for Food Stamps Assistance.
- To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.
- I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.



Signature MUST BE COMPLETED

Under penalty of perjury, I swear or affirm 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.

Signature _____ Date _____

Signature _____ Date _____

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 _____

Address _____ City _____ State _____ Zip _____

Signature of Authorized Representative _____