

STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

**STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES**

**Supplemental Nutrition Assistance Program
(Formerly known as the Food Stamp Program)**

This is your Six Month / Interim Report. You must:

- Answer all of the questions on this form
- Sign and return this form to the address listed above

You Must Sign the Signature Line

You do not have to come into the office at this time. If we have any questions about what you tell us, we will call you.

Please write a telephone number where you can be reached:_____.

If this form is not completed and returned by the due date your SNAP benefits will end.

YOU MUST ANSWER EACH SECTION BELOW AND PROVIDE VERIFICATION OF THE INFORMATION REQUESTED IN THE QUESTIONS.

SECTION 1 – ADDRESS / SHELTER EXPENSE INFORMATION

If the address listed above is not your current address, write your new address below. If your address has changed, you must enclose proof of your new address, shelter and utility expenses.

Even if your address has not changed, you may report and enclose proof of any change in shelter and utility expenses.

Do you have expenses where you currently live? YES NO

In order to receive a deduction for your expenses, you must provide proof / verification, such as a copy of your lease, rent receipt, mortgage statement, tax bill, home insurance bill, heating or air conditioning bill.

Do you have an expense for Rent or Room \$ _____ per _____
Mortgage \$ _____ per _____
Property Taxes \$ _____ per _____
Home Insurance \$ _____ per _____

Do you pay the gas, oil, electricity or other bill for your main heating system?

YES NO

Do you pay the electric bill or an extra charge for your rent for air conditioning?

YES NO

If you have no expenses for heating or cooling, list any other expenses for where you live:

Kind of expense _____ \$ _____ per _____
Kind of expense _____ \$ _____ per _____
Kind of expense _____ \$ _____ per _____

SECTION 2– CHILD SUPPORT PAYMENTS

Is anyone living with you court-ordered to pay child support?

YES \$ _____ per _____ (Include Verification) NO

SECTION 3 – HOUSEHOLD MEMBERS

Fill in the boxes below about each person in your household. Use an additional sheet of paper if more room is needed.

| Last Name | First Name | MI | Relationship to you | Date of Birth | Social Security Number |
|-----------|------------|----|---------------------|---------------|------------------------|
| | | | SELF | | |
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SECTION 4 – HOUSEHOLD INCOME

Provide the following information for any person in your household who has any income from working. You must include proof of income for the past thirty days, e.g., paycheck stubs or, if self-employed include signed statements of gross earnings and self-employment expenses.

| Person with Income | Employer / Business | Amount / How Often |
|--------------------|---------------------|--------------------|
| | | Per |
| | | Per |
| | | Per |
| | | Per |

SECTION 5 – UNEARNED INCOME

Please provide the following information for any person in your household that has unearned income. Examples of unearned income are: Social Security (RSDI, SSI), Unemployment Compensation, Child Support, Veteran’s Benefits, Dividends, Interest, Alimony, and TDI.

| Person with Income | Type of Unearned Income | Amount / How Often |
|--------------------|-------------------------|--------------------|
| | | Per |
| | | Per |
| | | Per |
| | | Per |

SECTION 6 - SIGNATURE

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge and belief. I know that under the State of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported. I understand that the information I provide on this form may result in a change or termination of my benefits.

SIGNATURE _____ DATE SIGNED _____

You have a RIGHT to non-discriminatory treatment. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Food and Nutrition Act of 2008 (formerly the Food Stamp Act); the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106); and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation. For further information about these laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, Rhode Island 02907, telephone number 415-8500 (for deaf/hearing impaired 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS' civil rights compliance.

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: http://www.ascr.usda.gov/complaint_filing_cust.html , 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: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov . This institution is an equal opportunity provider.

You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and SNAP Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

The chart below shows you some examples of the documents you will need to submit along with this Interim Report Form. Return this completed Interim Report form even if you don't have all of these documents. If you need assistance obtaining these documents, you may contact the worker listed on page 1 of this form.

| | |
|------------------------------------|---|
| Earned Income | Pay stubs or statement on employer letterhead showing income before taxes, pay dates, hourly work schedule and the number of hours worked for the past four weeks |
| Residence and Shelter Costs | Rent receipt, mortgage payment book, rent/lease agreement, statement from HUD, statement from person who shares shelter costs, utility bills, statement from utility company, statement from landlord |
| Child Support that You Pay | If your obligation to pay child support has changed, provide a copy of the court order. |
| Unearned Income | Most recent copy of Social Security check or award letter; proof of unemployment, worker's compensation, pension, child support, alimony, child support, TDI received |