DATE: _____

NAME: _____

ADDRESS: _____

_____

_____

CASE NUMBER: _____

DEPARTMENT OF HUMAN SERVICES
SNAP RECERTIFICATION FORM

Your Supplemental Nutrition Assistance Program (SNAP) benefits will end unless you recertify.

YOU MUST:

- **ANSWER ALL QUESTIONS ON THIS FORM (USE ADDITIONAL PAPER IF NEEDED)**
- **SIGN AND DATE THIS FORM.**
- **ATTACH ALL REQUIRED DOCUMENTS.**
- **RETURN THIS FORM TO THE DHS OFFICE.**
- **COMPLETE AN INTERVIEW.**

Your recertification form may be submitted and returned in person, through mail or by faxing it to one of the following numbers based on your office location:

Providence fax:	**(401) 415-8349 or (40l) 415-8557**	**Woonsocket fax:**	**(401) 768-3131**
Pawtucket fax:	**(401) 721-6659**	**South County fax:**	**(401) 782-4316**
Newport fax:	**(401) 619-7201**	**Warwick fax:**	**(401) 736-1442 or (401) 736-1443**

In order to process your recertification, you must complete an interview. A DHS worker will contact you or send a separate letter with the date and time of your interview once your recertification form is received. If you do not receive a phone call or your appointment letter within 10 days of submitting your recertification form to DHS, contact your local DHS office. If you miss your interview appointment, it is your responsibility to reschedule the appointment and provide required verification information. Your interviews can be conducted by telephone or in person at the DHS office.

Please provide a telephone number where you can be reached: _____

****

LANGUAGE:

PRIMARY LANGUAGE

CHANGES to Primary Language

_____

Do you need an Interpreter? YES___NO___
If needed, interpreter services are provided free of charge.
Can you read and write in English? YES___NO___ If you do not speak English, does any adult member of the Household speak English? YES___NO___

****

ADDRESS:

HOME ADDRESS:

_____

_____

_____

MAILING ADDRESS (IF DIFFERENT):

_____

_____

_____

ATTACH Proof of Residency. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

****

WHO LIVES IN YOUR HOME?

NAME OF PERSON	Relationship To You	Requesing SNAP?	Date Left if Person Left Home
_____	_____	YES___NO___	___/___/___
_____	_____	YES___NO___	___/___/___
_____	_____	YES___NO___	___/___/___

NAME any NEW household MEMBERS

NAME OF NEW PERSON	SEX	Birth Date	Relationship To You
_____	M___F___	___/___/___	_____
_____	M___F___	___/___/___	_____

MM DD YYYY

For each NEW household MEMBER requesting benefits, answer the following:

NAME OF NEW PERSON	Social Security Number	Is this person a U.S. Citizen?
_____	___-___-___	YES___NO___
_____	___-___-___	YES___NO___

ATTACH Proof of Identity. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

****

OTHER INFORMATION ABOUT MEMBERS OF YOUR HOUSEHOLD:

Are you, your spouse or anyone in your household living in any of the places listed below? YES____NO____

Approved/Drug/Alcohol Rehab Center	Elderly Disabled Housing
Disabled/Blind Living in Group Home	Battered Women's Shelter
Residential Care & Assisted Living	Shelter for Homeless
Long Term Care facility	Halfway House

If yes, complete the following information:

NAME OF GROUP LIVING FACILITY	NAME OF PERSON
_____	_____

Other than you and your spouse, are there any other parents with children under age 22 living with you? YES____NO____

If yes, complete the following questions:

NAME OF PARENT	NAME OF CHILD
_____	_____
_____	_____
_____	_____

For any person in your household that is sixteen (16) or older, write in the school or job training information below:

NAME OF PERSON	School/ Training Program	Full or Half Time?	Completion Date
_____	_____	_____	____/____/_____
_____	_____	_____	____/____/ ___MM DD YYYY

Is there someone in your home who does not purchase and prepare meals with you?

If YES, write in the information below:

NAME OF PERSON

_____

_____

Is anyone in the household mentally or physically ill, incapacitated, disabled or blind?

If YES, write in the information below:

NAME OF PERSON	MEDICAL PROBLEM
_____	_____
_____	_____

****

UNEMPLOYMENT:

Is anyone in the household unemployed or only working part time? If YES, write in the information below:

NAME OF PERSON	Unemployed?	Working Part Time?
_____	YES____NO____	YES____NO____

Did this person refuse a job or training program offer in the last 30 days? YES____NO____

Dates received Unemployment Compensation in the last 12 months:
FROM:_____/_____/_____ TO:_____/_____/_____

List the hours and weeks worked in the past 30 days below:

Week	Date	No. of Days Worked	Employer Name	Employment Dates	Amount Earned
WEEK 1	/	/	_____	____/____/____TO: ____/____/____	_____
_____			_____	____/____/____TO:____/____/____	_____
WEEK 2	/	/	_____	____/____/____TO:____/____/____	_____
_____			_____	____/____/____TO:____/____/____	_____
WEEK 3	/	/	_____	____/____/____TO:____/____/____	_____
_____					
WEEK 4	/	/			
_____					
WEEK 5	/	/_____	_____		

****

JOB INCOME:

Does anyone in the household, including children, receive income from a job? YES____NO____

If YES, write in the information below:

PERSON WITH INCOME	EMPLOYER NAME
_____	_____

Complete the following information from the pay stubs for the last FOUR (4) weeks:

DATE PAID MM / DD / YYYY	HOURS	GROSS WAGES BEFORE TAXES	TIPS/ COMMISSION	OTHER
1._____/_____/_____		$_____	$_____	$_____
2._____/_____/_____		$_____	$_____	$_____
3._____/_____/_____		$_____	$_____	$_____
4._____/_____/_____		$_____	$_____	$_____

ATTACH Proof of Earned Income. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

****

BUSINESS INCOME:

Does anyone in the household currently receive income from a business he/she owns (self-employment)?

YES____NO____

If YES, write in the information below:

PERSON WITH BUSINESS INCOME BUSINESS NAME OR TYPE OF BUSINESS

_____ _____

What is the gross income (before expenses) received each month? $_____/month

ATTACH Proof of gross income earned for last month and related expenses, if any. Allowable expenses may include labor, materials, supplies, taxes, rent (if not home-based business), travel expenses, interest on loans to purchase equipment/other property.

****

OTHER INCOME:

Do you or anyone in your household receive ANY OTHER income from:

a) CHILD CARE, which is provided for other children? YES____NO____
If YES, how many total children are cared for? _____

b) RENTAL PROPERTY that is owned or managed? YES____NO____
If YES, how many units in the property? _____
Do you live in one of the units? YES____NO____

c) RENTING OUT A ROOM in your home to someone? YES____NO____

If YES, do you provide meals with the room? YES____NO____

If you said 'Yes' to any of these types of income, complete the following information:

PERSON WITH INCOME	Type of Income	Gross Income Amount/How Often*
_____	_____	$_____PER_____
_____	_____	$_____PER_____
_____	_____	$_____PER_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.

ATTACH Proof of gross income earned for last month and related expenses, if any. Allowable expenses are those that are essential to producing or providing the services.

Do you or anyone in your household, including children, receive ANY OTHER income that IS NOT from a job or self-employment? YES____NO____

(Examples: Child Support, SSI/RSDI benefits, Worker's Comp, TDI, Unemployment Insurance, Pensions, Alimony, Interest/Dividends, Adoption Subisdy, Veteran's Benefits, Military/Dependent Allotment, etc.)

If YES, complete the following information:

PERSON WITH UNEARNED INCOME	Type of Income	Amount/How Often*
_____	_____	$_____PER_____
_____	_____	$_____PER_____
_____	_____	$_____PER_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.

ATTACH Proof of Unearned Income. Refer to the DOCUMENTS YOU NEED FOR BENEFIT APPROVAL.

Are you or anyone in your household waiting for a decision about being able to collect any of the above types of income?

YES____NO____

If YES, write in the information below:

PERSON WHO APPLIED FOR BENEFITS	Type of Benefit	Date Expected
_____	_____	____/____/_____

****

EXPENSES:

Does anyone in your household pay for day care for the care of a child or a disabled adult household member?

YES____NO____

If YES, write in the information below:

PERSON PAYING FOR CARE	Person Receiving Care	Amount Paid	How Often*
_____	_____	_____	_____
_____	_____	_____	_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.

ATTACH Proof of Dependent Care. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

Does anyone in your household pay court-ordered child support to another household? YES____NO____

If YES, write in the information below:

PERSON PAYING SUPPORT	To Whom Paid	Amount Paid	How Often*
_____	_____	_____	_____
_____	_____	_____	_____

ATTACH Proof of Child Support Paid. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

Do you or anyone in your household pay all or a share of rent, mortgage payment, property taxes, insurance, or other housing costs? YES____NO____

If YES, complete the following information:

TYPE OF EXPENSE	Amount/How Often*
_____	_____PER_____
_____	_____PER_____
_____	_____PER_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.
ATTACH Proof of Shelter Costs. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL. Did you get a Low Income Energy Assistance Act (LIHEAA) Grant at your current address in the last twelve (12) months?

YES____NO____

Do you or anyone in your household pay for utilities? YES____NO____

If YES, write in the information below:

PERSON PAYING UTILITY	Type of Utility	Amount/How Often*
_____	_____	_____PER_____
_____	_____	_____PER_____
_____	_____	_____PER_____
_____	_____	_____PER_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.
ATTACH Proof of Shelter Costs. Refer to the DCOUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

Does anyone in your household who is disabled or age 60 or older pay medical costs not covered by insurance?

YES____NO____

If YES, write in the information belw:

PERSON PAYING MEDICAL	Type of Medical Cost	Amount/How Often*
_____	_____	_____PER_____
_____	_____	_____PER_____
_____	_____	_____PER_____
_____	_____	_____PER_____

*HOW OFTEN: Weekly, bi-weekly, monthly, bi-monthly, quarterly, etc.
ATTACH Proof of Medical Expenses. Refer to the DOCUMENTS YOU MAY NEED FOR BENEFIT APPROVAL.

****

COMPLETING FORM:

Did anyone help you complete this form? YES____NO____

If YES, write in the information below:

PERSON'S NAME	PHONE NUMBER	AGENCY (if appropriate)
_____	_____	_____

****

PENALTIES FOR PERJURY

I certify under penalty of perjury that I have read (or had read to me) and I understand the Notice of Rights, Responsibilities and Penalties and that my answers are correct, including information about citizenship and alien status, 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.

_____ _____

Signature of Applicant or Recipient Date

_____ _____

Signature of Guardian, Power Attorney, or Authorized Representative Date

PLEASE DETACH YOUR RIGHTS AND RESPONSIBILITIES AND KEEP FOR YOUR RECORDS.

RIGHTS AND RESPONSIBILITIES
Of Applicants/Recipients of Supplemental Nutrition Assistance Program (SNAP)

RIGHTS

You have a RIGHT to request, and if found eligible, to receive Supplemental Nutrition Assistance Program benefits based on policies and standards established under State and Federal laws and regulations.

You have a RIGHT to appeal and to receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a Hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. If you are not satisfied with any Department decision regarding your application, you have a right to request a hearing. You must request a hearing within ninety (90) days from the date you receive a written notice for Supplemental Nutrition Assistance Program benefits.

You have a RIGHT to non-discriminatory treatment. 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.

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 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, gender identity or expression. For further information about these non-discrimination laws, regulations and 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 1-800-745-5555 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 civil rights compliance for all agency programs.

You have a RIGHT to confidentiality. Under state law, all agencies administrating programs included as part of this application are bound by state and federal laws and regulations to use 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, 40-6-12.1, and 42-7.2-5(13), regulations

set forth in the DHS Administrative Code. 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.

You have a RIGHT to file a joint application for more than one program or file a separate application for SNAP benefits without applying for other program benefits. All SNAP applications, regardless of whether they are joint applications or separate applications, must be processed for SNAP purposes in accordance with procedural, timeliness, notice, and fair hearing requirements. No household shall have its SNAP application denied solely on the basis that its application to participate in another program has been denied or its benefits under another program have been terminated without a separate determination by the appropriate agency that the household failed to satisfy a SNAP eligibility requirement. Households that file a joint application for SNAP and another program and are denied benefits for the other program shall not be required to resubmit the joint application or to file another application for SNAP, but shall have its SNAP eligibility determined based on the joint application in accordance with the SNAP processing time frames from the date the joint application was accepted by the Department.

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the household, to act on behalf of the household in applying for program benefits, or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply accurate information about your income, resources and living arrangements on this recertification.

You have a RESPONSIBILITY to tell us immediately (within ten (10) days) of any changes in your income, resources, family composition, or any other changes that affect your household. If you are a simplified reporter, you must report changes in income which bring the household's gross income in excess of the applicable SNAP Gross Income Eligibility Standard for your household size. If you are unsure about your reporting requirements, contact DHS for assistance.

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036 and under Federal Law (45 CFR 155.305 and 42 CFR 435.910). This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP, Medicaid, RIW, GPA, CCAP, Private Health Insurance with Financial Help. The Department will verify this information through computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, Medicaid, and Private Health Insurance with Financial Help. This information will also be used to monitor compliance with program regulations, for program management as well as to prevent fraud and verify health care claims.

This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a

SSN will result in the denial of benefits to any individual applying for benefits. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

You have a RESPONSIBILITY to report and provide proof of your expenses in order to get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

You have a RESPONSIBILITY to cooperate fully with state and federal personnel conducting quality control reviews.

Only U.S. citizens and certain legal immigrants may be eligible for SNAP benefits. If there are non-citizens living with you who are not eligible, you may still apply for and receive benefits for other eligible household members. You are not required to provide immigration information for people not applying for benefits, but you may need to provide other information for those people, such as, income and resources.

SNAP EBT Card Replacement Provisions:
Cardholders who request four (4) or more replacement EBT cards within a twelve (12) month period may be referred to the Fraud Unit for investigation of misuse or abuse of the EBT card. Documented violations may result in one or more of the following actions:

- Disqualification from the program;
- Recovery through recoupment/restitution; and/or
- Referral for criminal prosecution

In all cases, the agency shall act to protect households containing homeless persons, elderly or disabled members, victims of crimes, and other vulnerable persons who may lose electronic benefits transfer cards but are not committing fraud.

I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

SNAP PENALTY WARNINGS

I understand that:
Any member of my household who intentionally breaks a SNAP rule will be barred from the SNAP from one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. S/he may also be subject to prosecution under other applicable Federal and State laws. S/he may also be barred from SNAP for an additional 18 months if court ordered. Any member of my household who intentionally breaks a SNAP rule can be barred from the Supplemental Nutrition Assistance Program:

- **For a period of one (1) year for the first violation, with the exceptions in numbers 1. through 5. below;**
- **For a period of two (2) years after the second violation, with the exceptions in numbers 1. through 5. below; and,**
- **Permanently for the third occasion of any intentional program violation.**

1. Individuals found by a Federal, State, or local court to have used or received SNAP benefits in a transaction involving the sale of firearms, ammunitions or explosives shall be permanently ineligible for the Supplemental Nutrition Assistance Program upon the first occasion of such violation.

2. Individuals found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the Supplemental Nutrition Assistance Program for a period of ten (10) years.

3. Individuals found guilty by a Federal, State or local court of law for using or receiving benefits in a transaction involving the sale of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) will not be eligible for benefits for two years for the first offense, and

permanently for the second offense.

4. Individuals found guilty by a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for SNAP benefits will be prohibited from participating in the SNAP for 24 months for the first offense and permanently for the second offense.

5. An individual convicted by a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.

Trafficking as defined in 7 CFR 271.2 means:

1) The buying, selling, stealing, or otherwise effecting an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;

2) The exchange of firearms, ammunition, explosives, or controlled substances for SNAP benefits;

3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;

4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or

5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

6) Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone."

DO NOT lie or hide information to get or continue to get SNAP benefits that your household should not get.
DO NOT use SNAP benefits to buy non-food items, such as alcoholic drinks and cigarettes or to pay on credit accounts.
DO NOT trade or sell (or attempt to trade or sell) EBT cards or use someone else's EBT card for your household.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.
DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.