Georgia Department of Human Services

Georgia Department of Human Services
Division of Family and Children Services
Supplemental Nutrition Assistance Program (SNAP)
Periodic Report Form

If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf- blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

To continue receiving your SNAP benefits, we need to know if there have been any changes in your household's income or expenses. Please complete **the entire** form, sign it, and mail it to your county DFCS office **no later than the 5th of the month**. You can locate your local office at **http://dfcs.georgia.gov/locations .** You may submit this periodic report to your county office by mail, hand-delivery, or online at https://www.gateway.ga.gov. If you submit this report **after** the 5th of the month, there may be a delay in your benefits. If the **entire form** is not completed, and not signed and returned, your SNAP case will close.

Client First and Last Name	Date of Birth	Social Security Number
Street Address Where You Live		
City	State	Zip Code
Are you homeless? Yes ___ or No ____		
Mailing Address (If Different)		
We may use your numbers to call or text about your case. Main Telephone Number	Other Contact Number	
Electronic Communication: Email: Yes ____ or No _____(optional) Text: Yes ____ or No _____ (optional)	Email Address (optional):	
What is your Preferred Language?		If an interview is required, will you need an interpreter? Yes_____ or No _____

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):

Do you have a disability that will require Reasonable Modification or Communication Assistance? Yes__ No___ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):
Sign Language interpreter____; TTY____ ; Large Print____; Electronic communication (email) ____; Braille_____; Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter___; Telephone call reminder of program deadlines_____; Telephonic signature (if applicable)_____; Face-to-face interview (home visit) _____; Other:_____
Do you need this Reasonable Modification or Communication Assistance one-time___or ongoing ___?
If possible, briefly explain when and how long you need this modification or assistance?

Authorized Representative:

Complete this section only if you want a person or an organization to fill out your periodic report, and/or use your EBT card to buy food when you cannot go to the store. Please check the box next to SNAP if you want to designate someone as your authorized representative. Please check which duties you want the person or organization to have.

Authorized Representative Program Type: SNAP ❑
Authorized Representative Duties: Sign application on applicant's behalf ❑ Complete and submit periodic report form ❑
Receive copies of notices and other communication ❑ Act on behalf of applicant in all other matters ❑

Georgia Department of Human Services

Georgia Department of Human Services
Division of Family and Children Services
Supplemental Nutrition Assistance Program (SNAP)
Periodic Report Form

Person Name: _____

Organization Name (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Email: Yes __ No __ (optional) Texting: Yes __ No __ (optional)

Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes ___or No ___

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance for Authorized Representatives (if applicable):

Does the Authorized Representative have a disability that will require Reasonable Modification or Communication Assistance? Yes___ No___ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):

Sign Language interpreter_; TTY_; Large Print_; Electronic communication (email)_; Braille_____; Video Relay___; Cued Speech Interpreter___; Oral Interpreter___; Tactile Interpreter___; Telephone call reminder of program deadlines____; Telephonic signature (if applicable) ____; Face-to-face interview (home visit) ___; Other: _____

Does the authorized representative need this Reasonable Modification or Communication Assistance one-time____ or ongoing____? If possible, briefly explain when and how long you need this modification or assistance?_____
_____

The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R.
§ 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members social security number(s). Anyone who is living in your household and is not applying for benefits may be treated as a **non-applicant**. Non- applicants do not have to give us information about their social security number, citizenship, or immigration status and are not eligible for benefits. Other household members may still be able to receive benefits if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their social security number (SSN). You will still need to tell us about **their** income and resources to determine the eligibility and benefit level of the household. We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status.
However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level. We will match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a SNAP claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status.

Georgia Department of Human Services

Georgia Department of Human Services
Division of Family and Children Services
Supplemental Nutrition Assistance Program (SNAP)
Periodic Report Form

HOUSEHOLD COMPOSITION

Did anyone move into or out of your home since your last renewal or periodic report? Yes No____ If yes, list the person and their relationship to you:

Name	Date Moved In/ Out	Relationship To You	Date of Birth	Social Security Number

ADDRESS

Did you recently move and have a change in your shelter expenses? Yes ___ No ____ If yes, complete the information below:

Is your new address the same as the address written above on page 1? Yes ____ No _____

New Rent or Mortgage Amount $ _____ If a mortgage, the annual property tax is $_____ , and the amount for annual homeowner's insurance is $ _____.

For rent, list your landlord's name and contact information: _____

Does anyone help you pay your rent, mortgage, or utilities? Yes __ No___ If yes, answer the following questions

Who pays the bills? _____ What bills are paid? _____

What amount is paid for each bill? (List each amount separately.) _____

_____ Who do they pay the bills to? _____

At your new address, what utilities do you pay for? _____

Do you pay heating or cooling costs? Yes____ No_____ Circle one: electricity, gas, or both

Are you receiving energy assistance (LIHEAP)? Yes _____ No_____

ABLE-BODIED ADULT WITHOUT DEPENDENTS (ABAWD)

Did your household have an Able-Bodied Adult Without Dependents (ABAWD) whose work hours fell below 20 hours per week or 80 hours per month? Yes _ No _____ If yes, complete the information below:

What is the name(s) of the ABAWD who was working 20-29 hours per week or 80 hours per month?

_____

How much did their work hours decrease by? _____

Did the household member(s) leave their employment? Yes ____ No ____

What was the reason for leaving the job? _____

Georgia Department of Human Services

Georgia Department of Human Services
Division of Family and Children Services
Supplemental Nutrition Assistance Program (SNAP)
Periodic Report Form

INCOME
Has anyone had a change in the wage rate, salary, full-time or part-time status or source of income received each month? Yes _____ No_____ If yes, list information about your pay from employment such as wages, bonuses, and tips, and provide proof of ALL income received in the last thirty (30) days.
Who had a change in income or employment? _____ Where does the income or employment come from? _____ _____ How often is the income received? (weekly, biweekly, semi-monthly, monthly) _____
Has anyone stopped working? Yes _____ No _____ If yes, complete the following and provide proof:
When did the income or employment stop? _____ What is the last payment amount received? _____
Has anyone started working? Yes _____ No _____ If yes, complete the following and provide proof:
When did the income or employment start? _____ What is the new amount of income? _____
SELF-EMPLOYMENT: Is anyone self-employed: Yes____No___(If **yes**, who?) _____ **Please provide proof of self-employment income through <u>tax files</u>, business records, receipts, bills, or statements from customers of an established business**. Is this business incorporated? ❑ Yes ❑ No Does this person have any self-employment expenses? ❑ Yes ❑No If **yes**, what type of expenses does this person have? _____ _____
UNEARNED INCOME: **Has anyone in your household had a change in unearned income of more than $100? Unearned income includes but is not limited to, Contributions, Social Security, SSI, VA, Child Support, Unemployment, Retirement, or any other income.** ❑Yes ❑ No If **yes**, complete the information below and <u>provide proof of all income received in the last 30 days.</u>

Name	Source	Amount	How Often?

Georgia Department of Human Services

Georgia Department of Human Services
Division of Family and Children Services
Supplemental Nutrition Assistance Program (SNAP)
Periodic Report Form

LOTTERY AND GAMBLING WINNINGS
Has anyone won substantial lottery or gambling winnings of at least $4,500 or above? Yes ____ No ____
If so, who? _____When? _____ Amount?_____

CHILD SUPPORT PAYMENTS
Are you or someone in your household obligated to pay child support to someone living outside of the home? Yes ____ No _
Who is obligated to pay? _____
How much is the obligated amount? _____
For whom is the child support paid? _____
To whom is child support paid? _____
How often is child support paid? _____
How much is the actual amount paid? _____

RESOURCES

Has anyone in your household had a change in resources? Yes____ No ___

If yes, complete chart below.

Resource Type	Owner	Amount/Value	Bank Name
Cash			
Checking/Savings			
Credit Union			
Stocks or Bonds			
Safe Deposit Box			

SNAP Penalties

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- Do not give false information or hide information to get benefits that your household should not get.
- Do not use SNAP or EBT cards that are not yours and do not let someone else use yours.
- Do not use SNAP benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell SNAP or EBT cards for illegal items, such as firearms, ammunition, or controlled substance (illegal drugs).

Any household member who breaks <u>any</u> of the SNAP rules on purpose can be barred from SNAP for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from SNAP for an additional 18 months if court-ordered.

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to SNAP requirements. I will also report if anyone in my household receives lottery or gambling winnings, in the gross amount of $4500 or more (before taxes or other amounts are withheld). I will report these winnings no later than 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my periodic report and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

Signature_____ Date_____

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____Yes

_____No

_____I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at: 2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

(Keep this document for your information)

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services ("the Department") is required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Department's programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Department provides reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities, communication assistance, such as sign language interpreters. Our help is free. The Department is not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (877) 423-4746 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, but you do not have to use a form to make a request.

How to File a Complaint

You have the right to make a complaint if the Department has discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights and ADA/Section 504 Coordinator at 47 Trinity Avenue, SW, Atlanta, GA 30334, (877) 423-4746.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact any DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "Nondiscrimination Statement".

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Do Not Send Applications to the USDA

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620- 1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights and ADA/Section 504 Coordinator at 47 Trinity Ave. SW, Atlanta, GA 30334, 877-423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, or call (877) 423-4746.

Do Not Send Applications to the USDA