OTHER INCOME AND BENEFITS

If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit.

☐ Alimony
☐ Railroad Retirement
☐ Worker's Compensation
☐ Military Allotment
☐ Lump Sum Cash Amounts
☐ Child Support
☐ Veteran's Pension/Benefit
☐ Pension or Retirement
☐ Money from Rental Income
☐ Social Security
☐ Unemployment Benefits
☐ Union Benefits
☐ Black Lung Benefits
☐ Temporary Cash Assistance
☐ SSI
☐ Education Grants or Loans
☐ Disability/Sick, Maternity Benefits
☐ Money from friends or relatives
☐ Mineral Rights
☐ Interest Dividends from Stocks, Bonds, Savings or Other Investments ☐ Other _____

If you checked yes to receiving, applying for or being denied any benefits, fill in below.

HOUSEHOLD MEMBER	TYPE OF BENEFIT	APPLIED		CLAIM NUMBER	RECEIVED		AMOUNT
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	

CHILD SUPPORT

Does any household member pay **legally obligated** child support to a **NON-HOUSEHOLD** member? ☐ Yes Who? ☐ No
(includes current payments, arrearages, health insurance)

PERSON WHO PAYS	TYPE OF PAYMENT	MONTHS PAID IN LAST 3 MONTHS	COURT ORDER AMOUNT	AMOUNT ACTUALLY PAID

Read each statement carefully and sign the last page

1. I understand the SNAP benefits are to be used by my family and me to purchase food or seeds. I cannot sell my SNAP benefits or use someone else's benefits for myself. SNAP benefits will not be used for any other purpose. I understand that I may not use my SNAP benefits to purchase food on credit. This means I cannot pay for food already purchased or food to be received in the future.

2. I understand that my SNAP benefits will be deposited in an EBT account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced. I also understand that if I do not use SNAP benefits deposited in an EBT account for a period of 180 days, that the benefits will be unavailable to me unless I contact the DHHR office, and after proper notice the benefits may be used to repay outstanding claims. I also understand that if I do not use benefits in an EBT account for a period of 365 days that the benefits will be removed from the account. I may voluntarily request that the benefits in my account be used to repay claims established against my SNAP benefits at any time.

3. I understand if I or any member of my household:
   a. Is found guilty in a federal, state, or local court of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances; is a convicted felon, for possession, use or distribution of a controlled substance(s); or is found guilty of trafficking $500 or more in SNAP benefits, the guilty party will be permanently disqualified from participating in the SNAP Program.
   b. Makes a false statement or misrepresentation of identity and/or residence or receive duplicate benefits at the same time, the responsible party will be disqualified from the SNAP program for 10 years.
   c. Is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense and permanently for the second offense.

4. I understand if I am found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, I will not receive SNAP benefits as follows: First Offense – one year; Second Offense – two years; Third Offense – permanently. In addition, I will have to repay any benefits received for which I was not eligible.

5. I understand that if I fail to report or verify any household expense(s) that may entitle my household to an income deduction; I will not receive that deduction. This means I may not receive the full amount of SNAP benefits for which my household may be eligible. I understand that once I report and verify the expense(s) as required, I have the right to receive any calculated deduction beginning the following month.

6. I understand that if I receive SNAP benefits I have to report when total household income exceeds the SNAP gross income limit. I also understand that I will be notified what this amount is and that I must report this to DHHR by the 10th of the month after the increase happens. I understand that none of the other SNAP reporting requirements listed on this form apply to my household.

7. I understand that unless I am exempt, I must comply with work requirements by registering with the **WorkForce West Virginia** and providing information about employment status and job availability.

8. I understand that if I refuse or quit employment or reduce my work hours to below 30 hours per week without good cause I may be penalized.

9. I understand that I am authorized to receive information and referral services about TANF-funded programs as well as other programs offered by the WV Department of Health and Human Resources and other organizations in West Virginia. I understand that this information will be included in every SNAP notification letter sent to me.

21. I give my permission to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to INS, SSA, BCSE, BMS, Bureau for Public Health, Division of Rehabilitation Services or any other State or Federal Agency, Department, or Organization primarily for the purpose of providing me with access to the services and benefits offered by these entities in an efficient manner that allows for coordination rather than duplication of service(s).

22. I understand that WV DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services, or activities. This notice is available in large print, on audio tape, or in Braille from any office. This notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State ADA Coordinator, Department of Administration, Building 1, Room 127E, 1900 Kanawha Blvd., East, Charleston, WV 25305-0139, or by phone Monday through Friday 9:00 am to 5:00 pm at 304-558-1783.

23. I give my permission for any financial institution, government agency, or department, physician (including psychiatrists, psychologists or other counselors), drug testing facility, hospital (including psychiatric hospitals), business concern, HIV/AIDS testing service, or other person with related information to release any information to the DHHR when this information is related to my receipt of assistance. I understand that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.

24. I understand that I will have to repay any SNAP benefits issued to me for which I was not eligible when the reason I received the incorrect benefits was because I gave incorrect or false information or if I fail to report changes that I am required to report, or because of an unintentional error made by me or by the DHHR. I understand if a SNAP claim arises against my household, the information on this application, including all SSN's, may be referred to Federal and State agencies for claims collection action. I understand that I may also be prosecuted for fraud and I understand that I may also be subject to verification by the DHHR. I also understand that any person who obtains benefits from the DHHR by means of a willfully false statement, impersonation, misrepresentation, or any other fraudulent device can be charged with fraud. Upon a conviction, punishment may be a fine up to $5,000 and/or sentence of 5 years in jail. Federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years.

25. I certify that all statements on this form have been read by me or to me and that I understand them and accept these responsibilities. I swear or affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, belief, and knowledge. I certify under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens or lawfully admitted immigrants.

Please sign and date the form below

X

_____ _____

Signature of SNAP Household Member Date

DFA-SNAP-1 (New 4/2012) Rev. 3/13