

*St. Vincent*

**POVERTY**

**Experience**

## **Caseworker #2**

### **Caseworker #2 Packet Contents:**

- 1 Caseworker #2 Instruction Sheet
- 1 Application for Benefits Form
- 1 Household Members Registration Form
- 3 Interview Sheets - A to C
- 3 Interview Sheets -D to F
- 4 Interview Sheets - G to L
- 4 Interview Sheets - S to V
- 4 Interview Sheets - W to Z
- 15 Fraud Forms
- 15 Authorization for Release of Information Forms
- 3 Assignment of Support Rights Forms
- 3 Statement of Loss Forms
- 3 Absent Parent Information Forms
- 12 Authorization to Participate Cards
- 1 business sign and 1 name tag
- 1 pen/pencil
- 1 clipboard for clients

### **General Information - Caseworker #2 works with two types of clients:**

- 1) Those who are applying for TANF and Food Stamps
- 2) Those who are applying just for Food Stamps

You will be asked to report on your experience with the families during the debriefing period at the end of the simulation.

### **Responsibilities:**

- 1) Receive the names – As the clients arrive, the receptionist will hand you their names. You should call the clients in turn when you are ready. If they haven't completed the necessary forms, they lose their turn and have to wait until you call them again.
- 2) Conduct an interview with the client – Aggressively question all clients, following the instructions on the appropriate Interview Sheet. The clients' names are listed at the top of the Interview Sheet. You may ask additional questions if you wish. (For clients whose Food Stamps or TANF checks were lost or stolen, make sure they have signed the Statement of Loss form and tell them to come back in a week for emergency food stamps. If they return the next week, determine the amount they should receive, based on the amounts listed on their Interview Sheet). Tell the client how much and what kind of aid the family will be receiving and when the client should return to the office, based on the information included in the Interview Sheet.
- 3) When clients return to receive Food Stamp benefits, give them an "Authorization to Participate" card. This card indicates the dollar amount of food stamps to be received.

# Application for Benefits form (1 of 2 Pages)

## A. Applicant Information

Name:	<b>FOR OFFICE USE ONLY</b>
Social Security Number:	DCN
Address:	Phone:
City, State, Zip:	Message Phone:
Previous Address:	
Previous City, State, Zip	

If your household circumstances change in any of the ways listed below, Federal law requires you to report the changes to your DFS office within ten (10) days. You must provide the Social Security Number (SSN) of all persons applying for our receiving food Stamps as a condition of eligibility. The SSN will be used to determine eligibility and level of benefits verify information, prevent duplicate issuances, and to facilitate mass changes in federal benefits (FS Act of 1977 & Public Law 97-98).

## A. Household Members. List Income and Resources (Savings, vehicles, etc. In C, D and E Below).

Name	Relationship	Birth date	Social Security No.	How long at this address	Disabled?

## C. Income

Name	Source	Amount	Rate of Pay	No. of Hours

## D. Vehicles

Does anyone in your household own a car or truck? List information below.

Owner	Make	Model	Year	Licensed Y/N	Value	Debt	How is vehicle used?

## E. Resources

Cash, Saving Account, Checking Account, Stocks, Bonds, Property, etc.

Name	Resource	Amount	Institution/Location

**For rent, mortgage and Utilities** (GAS, Electric, oil, Etc.) food Stamps only

Use the space below to tell us which costs you are paying, and how often you are billed (Attach verification).

If your utilities are more than \$354 you may be eligible to use the actual amount.

Type of Expense	Amount	Institution/Location

**G. Dependent Care Costs** (Attach verification) optional If food Stamps only

Provider's Name	Phone number	Amount	How often billed?

**H. Child Support Expense List** any legally binding child support paid to non household members.

Dependent's Name	Amount Paid	How often paid
1.		
2.		
3.		

**I. For TANF** Please provide any information about the absent parent

Child's Name	Absent Parent	Absent Parent's SSN

**J. Other:** Please report any other circumstances here: Examples: medical insurance coverage, marital status, ownership of property, etc. Optional if Food Stamps only.


**IF YOU PURPOSELY HOLD BACK INFORMATION ABOUT CHANGES IN YOUR HOUSEHOLD, YOU WILL OWE US THE VALUE OF ANY EXTRA BENEFITS YOU RECEIVE AS A RESULT. YOU MAY ALSO BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS, 12 MONTHS, OR PERMANENTLY AND BE FINED, IMPRISONED, OR BOTH. YOU MAY ALSO LOSE YOUR TANF STANDARD DEDUCTION, EARNINGS DISREGARDS AND CHILD CARE EXPENSE DEDUCTIONS.**

**PENALTY WARNING:** Any information provided on this form is subject to verification by Federal, State, and local officials. If any is inaccurate, you may be denied food stamps and/or be subject to criminal prosecution for knowingly providing false information. Section 13942 of P.L. 103-66. Any individual found guilty in a federal, state or local court of trading coupons for controlled substance- es can be barred from the Food Stamp program permanently. Anyone who knowingly uses, acquires, alters or possesses coupons or au- theorization cards or presents coupons and knows they were received, transferred or used incorrectly violates this Act and is punishable by fines and/or imprisonment.

I understand the penalty for hiding or giving false information. I also understand I will owe the value of any extra benefits I receive because I don't fully report changes in my household. My signature below certifies under penalty of perjury that all declarations made on this change report are true, accurate and complete.

Client Signature	Telephone number	Date
------------------	------------------	------

# Household Members Registration (1 Page)

CASE NAME		CASE DCN				DATE APPLIED	
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
AF FS DC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	9. DCN	NAME (LAST, FIRST, MI, MAIDEN)					
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #	WIN	UP
LOAD # >	WORKER # >	SUP. # >					

## Welfare Office Interview Sheet – for ABER, BOLING, CHEN

Family name \_\_\_\_\_

1. Ask to see the client's completed Application for Benefits and Household Registration forms. Briefly review them and make sure client has signed them.
2. Ask the following questions, and record the client's answers:
  - A. What income does your family have? \_\_\_\_\_
  - B. How much money do you have in the bank? \_\_\_\_\_
  - C. What are your housing costs? \_\_\_\_\_
  - D. When did you last work? \_\_\_\_\_
  - E. Are you eligible for unemployment? \_\_\_\_\_
  - F. What debts do you have? \_\_\_\_\_
  - G. What resources do you own? (cars, savings bonds, etc.) \_\_\_\_\_
3. Have the client read and sign the Fraud Form and the Authorization for Release of Information Form.
4. If the family admits that they have a car valued at \$6,000, they may not be eligible for TANF in certain states. If they don't have a car of that value, they may be eligible for \$684 per month. Tell the client this is a decision that will be made next month. Remind them that they could be prosecuted if they lied about their assets.
5. Using the table below, determine the food stamp benefits the family will be eligible for based on when they applied. If they applied in:
 

First week of simulation:	\$ 536
Second week of simulation:	\$ 396
Third week of simulation:	\$ 256
Fourth week of simulation:	\$ 58

Amount of food stamp benefits family will receive is: \_\_\_\_\_
6. Tell the client how much their benefit will be and that the client should come back in a week to receive their Authorizations to Participate (ATP) card.
7. When the client returns, issue Authorization to Participate card in amount noted above.
8. After client has received the ATP card, please complete:

ATP Care issued in the amount of \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Caseworker: \_\_\_\_\_

# Welfare Office Interview Sheet

For DUNTLEY, EPPERMAN, FUENTES

Family name \_\_\_\_\_

1. Ask to see the client's completed Application for Benefits and Household Registration forms. Briefly review them and make sure client has signed them.
2. Ask the following questions, and record the client's answers:
  - A. What income does your family have? \_\_\_\_\_
  - B. What resources do you own? \_\_\_\_\_
  - C. What is your rent? \_\_\_\_\_
  - D. How much do you pay for utilities? \_\_\_\_\_
  - E. What was your last job? \_\_\_\_\_
  - F. What debts do you have? \_\_\_\_\_
  - G. Where is the father of your children? \_\_\_\_\_
  - H. Why did he leave? \_\_\_\_\_
  - I. How can he be found? \_\_\_\_\_
  - J. When did you last see him? \_\_\_\_\_
  - K. Explain that Child support Enforcement wants to know when was the last time you were intimate with him? \_\_\_\_\_
3. Have the client read and sign the Fraud Form, the Authorization for Release of Information Form, the Assignment of Support Rights Form, and the Absent Parent Information Form.
4. Explain that the family is eligible for TANF in the amount of \$ 584 a month, but that it takes 30 to 40 days to process their application, so they should come back next month for their check.
5. Explain that the family is probably eligible for emergency food stamps. Using the table below, determine the food stamp benefits the family will be eligible for based on when they applied (out of a maximum of \$ 626. If they applied in:
 

First week of simulation:	\$ 442
Second week of simulation:	\$ 310
Third week of simulation:	\$ 200
Fourth week of simulation:	\$ 90

Amount of food stamp benefits family will receive is: \_\_\_\_\_
6. Tell the client how much their benefit will be and that the client should come back in a week to receive their Authorizations to Participate (ATP) card.
7. When the client returns, issue Authorization to Participate card in amount noted above.
8. After client has received the ATP card, please complete:

ATP Care issued in the amount of \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Caseworker: \_\_\_\_\_

# Welfare Office Interview Sheet

For GONZALEZ, HANLOW, ISMA, JOLLY, KAMINSKI, LOUIS

Family name \_\_\_\_\_

1. Ask to see the client's completed Change Report Form. Briefly review them and make sure client has signed it.
  
2. Ask the following questions, and record the client's answers:
  - A. How many are in your household? \_\_\_\_\_  
(If there are more than three persons, the client's benefits will change.)
  - B. How much income do you currently have? \_\_\_\_\_
  - C. What additional resources do you have? \_\_\_\_\_
  - D. What is your rent? \_\_\_\_\_
  - E. How much do you pay for utilities? \_\_\_\_\_
  - F. Do you have medical expenses? \_\_\_\_\_
  - G. Why aren't you employed? \_\_\_\_\_
  - H. What debts do you have? \_\_\_\_\_
  
3. Have the client read and sign the Fraud Form and the Authorization for Release of Information Form.  
*If the client asks questions about the form, tell her to read them.*
  
4. If no changes have been reported, tell the client that based on the information she has given you, the family will continue to receive \$ 584 a month from TANF and an additional \$630 in food stamps.
  
5. If changes have been reported, tell the client that a decision about a new benefits level will be made next month.

Date: \_\_\_\_\_

Signature of Caseworker: \_\_\_\_\_

## Welfare Office Interview Sheet

For SMITH, TISKIT, USSAR, VIMMER

Family name \_\_\_\_\_

1. Ask to see the client's completed Application for Benefits and Household Registration forms. Briefly review them and make sure client has signed them.
2. Ask the following questions, and record the client's answers:
  - A. What is your income? \_\_\_\_\_
  - B. What resources do you own? \_\_\_\_\_
  - C. What are your housing costs? \_\_\_\_\_
  - D. How much do you pay for utilities? \_\_\_\_\_
  - E. What debts do you have? \_\_\_\_\_
  - F. Do you have medical expenses? \_\_\_\_\_
3. Have the client read and sign the Fraud Form and the Authorization for Release of Information Form.
4. Explain that based on her income of \$ 970 a month, she is eligible for food stamps, but that she will have to come back in two weeks to receive authorization. Using the table below, determine the food stamp benefits the family will be eligible for based on when they applied (out of a maximum of \$ 200 monthly. If they applied in:
 

First week of simulation:	\$ 126
Second week of simulation:	\$ 84
Third week of simulation:	Tell her she will get food stamps next month.

Amount of food stamp benefits family will receive is: \_\_\_\_\_
5. Tell the client how much their benefit will be and that the client should come back in a week to receive their Authorizations to Participate (ATP) card.
6. If client returns, issue Authorization to Participate card in amount noted above. Then complete:

ATP Care issued in the amount of \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Caseworker: \_\_\_\_\_



# Welfare Office Interview Sheet

For WISCOTT, XANTHOS, YARROW, ZUPPOT

Family name \_\_\_\_\_

1. Ask to see the client's completed Application for Benefits and Household Registration forms. Briefly review them and make sure client has signed them.
2. Ask the following questions, and record the client's answers:
  - A. What is your income? \_\_\_\_\_
  - B. What resources do you own? \_\_\_\_\_
  - C. What is your rent? \_\_\_\_\_
  - D. How much do you pay for utilities? \_\_\_\_\_
  - E. What debts do you have? \_\_\_\_\_
  - F. Do you have medical expenses? \_\_\_\_\_
3. Have the client read and sign the Fraud Form and the Authorization for Release of Information Form.
4. Explain that based on the SSI income of \$ 1452 a month, the family is eligible for food stamps, but that the client will have to come back I two weeks to receive authorization. Using the table below, determine the food stamp benefits the family will be eligible for based on when they applied (out of a maximum of \$202). If they applied: :  
First week of simulation: \$ 146  
Second week of simulation: \$ 96  
Third week of simulation: Tell them they will bet food stamps next month.  
  
Amount of food stamp benefits family will receive is: \_\_\_\_\_
6. Tell the client how much their benefit will be and that the client should come back in a week to receive their Authorizations to Participate (ATP) card.
7. If client returns, issue Authorization to Participate card in amount noted above.
8. After client has received the ATP card, please complete:

ATP Care issued in the amount of \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Caseworker: \_\_\_\_\_

# FRAUD FORM (1 Page)

## Notification and acknowledgement of fraud provisions

1. Poverty state law, Section 205.967 RSMo., provides that it is the crime of stealing if a person obtains, attempts to obtain or aids and abets another in obtaining any public assistance benefits by:
  - (a) Means of willfully false statements or representation, or
  - (b) Willful concealment of failure to report any fact or event required to be reported by any law, regulation or rule of this state or the United States, or
  - (c) By impersonation, collusion or other fraudulent devise.

Public Assistance benefits means anything of value, including money, food, food stamps, commodities, clothing, utilities, utility payments, shelter, drugs and medicine, materials, goods and any service including institutional care, medical care, child care, psychiatric and psychological service, rehabilitation, instruction, training or counseling or benefits, programs and services provided or administered by the State of Poverty Department of Social Services.

The crime of stealing or attempting to steal public assistance benefits of a value greater than three hundred dollars (\$300.00), upon conviction, is punishable by imprisonment for a period not to exceed five years; or by confinement in the county jail for a period not to exceed one year; or by a fine not to exceed two thousand dollars (\$2,000), or both. If the value of the unlawfully obtained benefits is less than three hundred dollars (\$300), the crime is a misdemeanor.

2. Any person who has been found by any State or Federal court or administrative agency to have intentionally made a false or misleading statement, or misrepresented, concealed or withheld facts, or committed any act that constitutes a violation of the Federal Food Stamp Act, the regulations issued there under, or any State statute, for the purpose of using, presenting, transferring, acquiring, receiving or possession coupons or authorization cards shall, immediately, upon the rendering of such determination, become ineligible and will be disqualified, for future participation in the program:
  - (a) for a period of six months upon the first occasion of any such determination;
  - (b) for a period of one year upon the second occasion or any such determination; and
  - (c) permanently upon the third occasion of any such determination.
3. It is a federal crime to use, transfer, acquire, alter, or possess coupons or authorization cards in any manner not authorized by the Food Stamp Act. It is a federal crime to present or cause to be presented, coupons received, transferred, or used in a manner in violation of this act. If convicted of such violations and the value of the coupons or authorization cards are two hundred dollars (\$200) or more, it is a felony punishable by a fine of not more than twenty thousand dollars (\$20,000) or imprisonment for not more than five years, or both. If convicted of such violation and the value of the coupons or authorization cards are less than two hundred dollars (\$200), it is a misdemeanor punishable by a fine of not more than two thousand dollars (\$2,000) or imprisonment for not more than one year, or both.

I, (we), have had the eligibility requirements of such programs explained, and have had the penalties above explained and fully understand I (we) will be subject to prosecution for violation of Section 205.967, RSMo, or the Food Stamp Act of 1977 as amended at 7 USC, 2024.

\_\_\_\_\_  
CASE WORKER

\_\_\_\_\_  
COUNTY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT OR RECIPIENT

\_\_\_\_\_  
SPOUSE OF APPLICANT OR RECIPIENT

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS TO SIGNATURE OR MARK

\_\_\_\_\_  
(WITNESS TO SIGNATURE OR MARK)

# Authorization for Release of Information (1 Page)

STATE OF POVERTY  
DEPARTMENT OF SOCIAL SERVICES  
DIVISION OF FAMILY SERVICES

COUNTY OFFICE: \_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
COUNTY DIRECTOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

CASEWORKER: \_\_\_\_\_

CASE NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of information regarding my \_\_\_\_\_

\_\_\_\_\_

situation to representatives of the State of Poverty, Division of Family Services.

Information shall be released by:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*I (we) hereby release any person, firm, physician, clinic, or hospital from any liability for information furnished pursuant to this authorization.*

SIGNED: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_

Signature of Other: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

# Assignment of Support Rights (1 Page)

**STATE OF POVERTY - DEPARTMENT OF SOCIAL SERVICES**  
DIVISION OF FAMILY SERVICES  
ASSIGNMENT OF SUPPORT RIGHTS TO  
THE DIVISION OF FAMILY SERVICES IN BEHALF OF THE STATE OF POVERTY

\_\_\_\_\_  
CASE NUMBER

I, \_\_\_\_\_, being an applicant for or recipient of Aid to Families with Dependent Children (AFDC) from the Division of Family Services, do hereby assign any and all vested, existing rights to receive support payments which are past due, currently due, or which will become due in the future to which I am entitled in my own behalf or in behalf of the child or children for whom I am applying for or receiving assistance payments to the Division of Family Services in behalf of the State of Poverty. This assignment shall take effect upon the approval of my application for assistance by the Division and shall remain in full force and effect so long as I am a recipient of assistance (AFDC). Upon the termination of my receipt of assistance payments, this assignment shall remain in effect as to the unpaid support obligations owing at the time of the discontinuance of assistance payments.

II. The names and birthdates of the child(ren) with respect to whom this assignment is made are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. I hereby agree that I will immediately forward to the Division of Family Services any and all support payments which I receive while this assignment is in effect>

IV. I hereby appoint the Director of the Division or his or her designee to act as my attorney in fact to perform the specific act of negotiating and endorsing over to the Division of Family Services in behalf of the State of Poverty any and all negotiable instruments (checks, money orders, etc.) representing support payments received in my behalf by the Division. This limited power of attorney is effective upon the approval of my application for assistance by the Division and shall remain in effect so long as I am a recipient of assistance payments.

V. The name of the person responsible for support of the above named child or children (other than yourself) \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
(Applicant/Recipient Signature)

\_\_\_\_\_  
(Formerly)

\_\_\_\_\_  
Name of Witness to Signature or Mark

\_\_\_\_\_  
Name of Witness to Signature or Mark

\_\_\_\_\_  
Address of Witness to Signature or Mark

\_\_\_\_\_  
Address of Witness to Signature or Mark

STATE OF POVERTY

On this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_, before me personally appeared \_\_\_\_\_ to me known to be the person described in and who executed the foregoing instrument and acknowledged that \_\_\_he executed the same as h\_\_\_ act and deed. Witness Whereof, I have hereunto set my hand and seal on the date first above written.

Commission Expires: \_\_\_\_\_ Notary Public: \_\_\_\_\_

# Statement of Loss (1 Page)

(1) Recipient Name: \_\_\_\_\_  
(Person ATP Card or Coupons were issued to)

(2) Current Address of Recipient: \_\_\_\_\_  
(Street No.) (Apt. No.) (Street)  
\_\_\_\_\_  
(City) (State)

(3) Address ATP Card was mailed to if different than above: \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State)

(4) List any other state public assistance programs recipient is participating in:  
Name of Program: \_\_\_\_\_ How long? \_\_\_\_\_

(5) Recipient Food Stamp Case Number: \_\_\_\_\_

(6) Any other state public assistance case number if applicable: \_\_\_\_\_

(7) The card in the amount of \$ \_\_\_\_\_ was ( ) not received ( ) destroyed ( ) stolen  
Coupons in the amount of \$ \_\_\_\_\_ were destroyed. WHEN: Date \_\_\_\_\_

(8) ATP CARD NUMBER: \_\_\_\_\_  
Replacement Card Number and \$ Amount: No. \_\_\_\_\_ Amt. \_\_\_\_\_

(9) If stolen, was police report made? ( ) Yes ( ) No WHEN? Date: \_\_\_\_\_  
Name of Police Agency reported to: \_\_\_\_\_  
Address: \_\_\_\_\_

(10) I, THE UNDERSIGNED, HEREBY DECLARE THAT I DID NOT:  
( ) Receive or use the ATP Card(s) issued and mailed to me for the month of \_\_\_\_, 20\_\_\_\_  
( ) Use the Food Stamp Coupons in the amount of \$ \_\_\_\_\_ for the month of \_\_\_\_, 20\_\_\_\_

I AGREE THAT IF I SHOULD RECEIVE OR RECOVER THE MISSING CARD(S) OR FOOD COUPONS, I WILL IMMEDIATELY RETURN IT TO MY CASEWORKER. FURTHERMORE, I UNDERSTAND THAT IF THE LOST CARD(S) OR FOOD COUPONS ARE USED EITHER BY ME OR BY ANY OTHER PERSON ACTING WITH MY KNOWLEDGE AND CONSENT, I WILL BE INELIGIBLE TO CONTINUE IN THE FOOD STAMP PROGRAM AND WILL BE LIABLE TO PROSECUTION UNDER BOTH FEDERAL AND STATE LAWS.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_

# Absent Parent Information form (1 of 2 pages)

## STATE OF POVERTY DIVISION OF FAMILY SERVICES

**LOCAL OFFICE COMPLETES:**

AFDC \_\_\_ Non-AFDC \_\_\_ Worker Name: \_\_\_\_\_ County: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Children: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Case # \_\_\_\_\_ Date First Opened: \_\_\_\_\_ Date Re-Opened \_\_\_\_\_

AFDC Grant Amount: \$ \_\_\_\_\_

**APPLICANT OR RECIPIENT COMPLETES:** *Every item on this form must be completed, even if the information has been asked before; This form provides the Support Enforcement Unit with essential facts to locate the absent parent and/or enforce the support obligation.*

<p><b>ABSENT PARENT INFO:</b>                  Name _____                  Alias: _____                  Address: _____                  _____                  Date Known: _____ Phone: _____                  SSN _____                  Birthdate: _____ Place: _____                  Race: _____ Sex: _____ Height: _____                  Weight: _____ Hair: _____ Eyes: _____</p> <p>-----</p> <p><b>MARITAL STATUS:</b>                  Are the parents of the children:  <input type="checkbox"/> Married      Date: _____  <input type="checkbox"/> Separated      Date: _____  <input type="checkbox"/> Divorced      Date: _____  <input type="checkbox"/> Never Married</p> <p>Is the Absent Parent now married to someone else?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown                  If yes, spouse's name: _____                  Have child support payments been ordered by Court?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   If yes, attach copy of court order                  and complete the court information.</p> <p>Court name: _____ Date: _____                  Order No. _____ Amt/Child _____                  Frequency: _____</p> <p>Does Absent Parent pay child support money?                  Amount: _____ Explain: _____                  _____                  _____</p>	<p><b>MARITAL STATUS AND COURT INFO.</b>                  Answer the following questions if parents were not married                  when child(ren) were born.</p> <p>Has paternity been legally established by a court?  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, attach a copy of court order information. Court                  name _____</p> <p>If no, has alleged parent ever admitted paternity of the                  child(ren)?   <input type="checkbox"/> Yes   <input type="checkbox"/> No   To whom?                  Name: _____                  Address: _____                  Name: _____                  Address: _____</p> <p>-----</p> <p><b>OCCUPATIONAL AND SOCIAL INFORMATION:</b>                  is this Absent Parent presently attending school?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</p> <p>Name: _____                  Address: _____</p> <p>What is Absent Parent's usual occupation: _____                  _____</p> <p>Does the Absent Parent belong to a union?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown                  Name and Local ID: _____</p> <p>Is this Absent Parent now employed?  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown                  If yes, work hours: _____ to _____                  Name of employer: _____</p>
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# Absent Parent Information form (2 of 2 pages)

<p><b>OCCUPATIONAL AND SOCIAL INFO (Cont'd)</b>                  List below the names and addresses of past employers and the approximate dates of employment for this Absent Parent.</p> <p>Employer: _____                  Address: _____                  Dates worked: From _____ To _____</p> <p>Employer: _____                  Address: _____                  Dates worked: From _____ To _____</p> <p>Employer: _____                  Address: _____                  Dates worked: From _____ To _____</p> <p>What are the names and addresses of this Absent parent's father and mother?                  Father Name _____                  Address _____</p> <p>Mother Name _____                  Address _____</p>	<p>Does this Absent Parent have any other income or receive any pensions such as unemployment or Social Security?                  ( ) Yes ( ) No If yes, please complete:</p> <p>Source: _____                  Amt: _____                  How Often? _____</p> <p>Source: _____                  Amt: _____                  How Often? _____</p> <p>If this Absent Parent has ever been convicted of a crime please answer these questions:                  Date Arrested: _____ Place: _____</p> <p>Is this Absent Parent in jail or prison NOW?                  ( ) Yes ( ) No ( ) Unknown If yes, give location: _____                  Parole Officer: _____</p>
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If you weren't able to give much information about this Absent Parent, please explain why:

\_\_\_\_\_

\_\_\_\_\_

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**I CERTIFY THAT INFORMATION GIVEN BY ME ON THIS FOR IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

Worker's Name \_\_\_\_\_ Signature: \_\_\_\_\_  
 County: \_\_\_\_\_ Load No: \_\_\_\_\_ Date: \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ before me personally appeared \_\_\_\_\_ to me known as to be the person described in and executed the foregoing instrument and acknowledgement that \_he executed the herein act and deed.

In witness Whereof, I have hereunto set my hand and seal on the date first above written.

My commission expires: \_\_\_\_\_ Notary Public: \_\_\_\_\_

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**FOR DFS OFFICE USE ONLY**

Date of first AFDC check on which support was not calculated: \_\_\_\_\_  
 NOTATIONS OF IM WORKER: \_\_\_\_\_  
 \_\_\_\_\_

# DO NOT LAMINATE

## AUTHORIZATION TO PARTICIPATE FOOD STAMP PROGRAM

STATE OF POVERTY – DEPARTMENT OF AGRICULTURE

Name \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_

Amount Authorized \_\_\_\_\_

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# Welfare Office

## Caseworker #2

Nametag

