St. Vincent

POVERTY
Experience

Caseworker #1

Caseworker #1 Packet Contents:

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1 pen/pencil
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General Information - Caseworker #1 works with three types of clients:

1) Those who are applying for TANF and Food Stamps
2) Those who are applying just for Food Stamps
3) Those who are already receiving TANF or 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).
3) When clients return to receive Food Stamp benefits, give them an "Authorization to Participate" card. This card indicates the dollar amount for food stamps to be received.

At some time during the first 2 weeks – Send "Notice to Appear" cards to families G through R who are already receiving benefits. (See Interview Sheets for names of families.) You may deliver the cards yourself or ask the Director to help. The clients are to come to you for their six-month recertification of benefits. When they come, interview them according to the procedure outlined in the Interview Sheets.

Application for Benefits Form (1 of 2 Pages)

A. Applicant Information

Name:	**FOR OFFICE USE ONLY**
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 ☐☐☐☐	1. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	2. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	3. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	4. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	5. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	6. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	7. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	8. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
AF FS DC ☐☐☐☐	9. DCN	NAME (LAST, FIRST, MI, MAIDEN)						
	DATE OF BIRTH	RACE	SEX	S S #	S S CLAIM #		WIN	UP
LOAD # >	WORKER # >	SUP. # >						

Change Report Form (3 Pages)

Date:_____

Name:_____
Address:_____
_____

Dear:_____

Use this form to report (within 10 days) any of the following changes in your household circumstances:

- Changes in your total household income when it comes up or down by $50 or more per month. You don't have to report changes in your AFDC check.
- Changes in any source of income.
- The value of any licensed vehicle, if anyone in your household gets one.
- Increases in your household's savings if the total cash and savings of all household members now amounts to $4,000 or more.
- Changes in the number of people in your household.
- Your new address if you move.
- Your new rent or mortgage costs if you move.
- When total medical expenses of household members age 60 or over, or who receive Supplemental Security (SSI) benefits or Social Security Disability payments, changes up or down by $50 or more a month.

You must report these changes within 10 days of the time you know of changes. This will help make sure you get the correct amount of stamps.

If for some reason you can't mail this form, you can report the changes by calling us at _____.

You can also use this form to report changes in the cost of earnings for children or disabled adults, or changes in the shelter costs even if you haven't moved. If these expenses go up you may be eligible for additional food stamps.

If you purposely hold back information about changes in your household, you will owe us the value of any extra food stamps 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 or imprisoned.

Sincerely,

Change Report Form (Cont'd)

If you didn't give your social security numbers

If you have not given social security numbers for all household members who are 18 years or over and those children under 18 years with countable income, list their names, ages and social security numbers (SSN) below.

Name 1._____Age:_____SSN_____

Name 2._____Age:_____SSN_____

Name 3._____Age:_____SSN_____

If income or any source of income changes

You must tell us if the total income received by your household goes up or down by $50 or more a month. In figuring the change, use your household's total monthly income before deductions such as taxes or retirement or union dues are taken out. You don't have to report changes in our FDC check, but you have to report changes in any other source of income. (For members currently on strike, enter income before the strike.)

Name 1. _____Inc source_____Amt_____How often____

Name 2. _____Inc source_____Amt_____How often____

Name 3. _____Inc source_____Amt_____How often____

If the number of cars or licensed vehicles changes

You must tell us if anyone in your household has gotten a car, truck, boat, camper, motorcycle or other licensed vehicle since the last time you told us about the vehicles your household owns.

Make:_____Model_____Year_____

Make:_____Model_____Year_____

Has anyone in your household sold or traded a licensed vehicle since the last time you told us about the vehicles your household owns? How much did you get for it?_____

Make:_____Model_____Year_____

Make:_____Model_____Year_____

If your savings increase

You must tell us if the total amount of money that members of your household have in cash, savings accounts, checking accounts and/or if stocks and bonds increase to more than $4,000. How much does your household have now?_____

If someone moves in or out

If someone moves in or out of your home, you must report that. Are there any new members of your household?. If so, please list them and complete the information below. Include newborn children.

Name 1._____( ) Left ( ) Entered ( ) is disabled A g e _____Income_____

Name 1._____( ) Left ( ) Entered ( ) is disabled A g e _____Income_____

Name 1._____( ) Left ( ) Entered ( ) is disabled Age_____Income_____

Change Report form (Cont'd)

If you moved or your rent or mortgage changed

If you moved, what is your new mailing address?

_____

If you don't have a street address, tell us how to get to your home. Phone_____

_____

_____

If you moved, you must also list your new expenses below. You can also use this section to tell us that your rent or mortgage has gone up.

_____

New amount_____Insurance_____Taxes_____

Are you a boarder? ( ) Yes ( ) No

If your utilities or dependent care costs go up

Have your utility bills (gas, oil, electricity, etc.) gone up? Have you started paying someone to care for a child or dependent adult or have these costs increased? If so, you may be eligible for more food stamps Use the space below to tell us which costs have gone up, the new amount you are paying and how often you are billed.

Type of cost:_____New amt_____How often_____

Type of cost:_____New amt_____How often_____Type of cost:_____

_____New amt_____How often_____

If certain household member's medical expenses go up or down

List the medical expenses for all household members age 60 or who are disabled and receive Supplemental Security Income (SSI) benefits or Social Security Disability payments if the total monthly medical expenses have gone up or down by $50 or more.

Medical and dental_____Amt_____How often____

Hospital or nursing_____Amt_____How often____

Health ins and medical pmts_____Amt_____How often____

Prescription drugs_____Amt_____How often____

Denture, hearing aids, glasses_____Amt_____How often____

Transportation to medical care_____Amt_____How often____

Services of nurse or attendant_____Amt_____How often____

Other (explain)_____Amt_____How often____

Please list the names of household members that have these expenses:

_____

Penalty Warning: Do not falsify any of the above information under penalty of law

Signature_____Date:_____

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 MORRIS, NATTIN, OLSON, PEREZ, QUANT, ROGERS

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 $ 568 a month from TANF and an additional $800 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 Sates, 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 that 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 that 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 (1Page)

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. 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 THELOST 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:_____

Instructions: Prepare in duplicate. Send copy to the Food Stamp Program Supervisor, Issuance State Office

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:_____Birth date:_____

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.*

ABSENT PARENT INFO:
Name_____
Alias:_____
Address:_____
_____
Date Known:_____Phone:_____
SSN_____
Birthdate:_____Place:_____
Race:_____Sex:_____Height:_____
Weight:_____Hair:_____Eyes:_____

MARITAL STATUS:
Are the parents of the children:
( ) Married Date:_____
( ) Separated Date:_____
( ) Divorced Date:_____
( ) Never Married

Is the Absent Parent now married to someone else?
( ) Yes ( ) No ( ) Unknown
If yes, spouse's name:_____
Have child support payments been ordered by Court?
( ) Yes ( ) No If yes, attach copy of court order and complete the court information.

Court name:_____Date:_____
Order No._____Amt/Child_____
Frequency:_____

Does Absent Parent pay child support money?

Amount:_____Explain:_____
_____
_____
_____

MARITAL STATUS AND COURT INFO.
Answer the following questions if parents were not married when child(ren)were born.

Has paternity been legally established by a court?
( ) Yes ( ) No

If yes, attach a coy of court order information. Court name_____

If no, has alleged parent every admitted paternity of the child(ren)? ( ) Yes ( ) No To whom?
Name:_____
Address:_____
Name:_____
Address:_____

OCCUPATIONAL AND SOCIAL INFORMATION:
is this Absent Parent presently attending school?
( ) Yes ( ) No ( ) Unknown

Name:_____
Address:_____

What is Absent Parent's usual occupation:_____
_____
Does the Absent Parent belong to a union?
( ) Yes ( ) No ( ) Unknown
Name and Local ID:_____

Is this Absent Parent now employed?
( ) Yes ( ) No ( ) Unknown
If yes, work hours:_____to _____

Name of employer:_____

Absent Parent Information Form (2 of 2 pages)

OCCUPATIONAL AND SOCIAL INFO (Cont'd)
List below the names and addresses of past employers and the approximate dates of employment for this Absent Parent.

Employer:_____
Address:_____
Dates worked: From _____To _____

Employer:_____
Address:_____
Dates worked: From _____To _____

Employer:_____
Address:_____
Dates worked: From _____To _____

What are the names and addresses of this absent parent's father and mother?
Father Name_____
Address_____

Mother Name_____
Address_____

Does this Absent Parent have any other income or receive any pensions such as unemployment or Social Security?
( ) Yes ( ) No If yes, please complete:

Source:_____
Amt:_____
How Often?_____

Source:_____
Amt:_____
How Often?_____

If this Absent Parent has ever been convicted of a crime please answer these questions:
Date Arrested:_____Place:_____

Is this Absent Parent in jail or prison NOW?
( ) Yes ( ) No ( ) Unknown If yes, give location:_____
Parole Officer: _____

If you weren't able to give much information about this Absent Parent, please explain why:
_____
_____
_____

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:_____

FOR DFS OFFICE USE ONLY

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

DO NOT LAMINATE

Division of Social Services

NOTICE TO APPEAR

____

(name)

You must report in person within 5 days to the State of Poverty Welfare Office for recertification of your benefits. Failure to do so will result in forfeiture of your benefits.

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DO NOT LAMINATE

AUTHORIZATION TO PARTICIPATE

FOOD STAMP PROGRAM

STATE OF POVERTY – DEPARTMENT OF AGRICULTURE

Name ______________________________

Address ____________________________

Social Security Number ________________

Amount Authorized ___________________

AUTHORIZATION TO PARTICIPATE

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Amount Authorized ___________________

Welfare Office

Caseworker #1

Nametag

Caseworker #1

Welfare Office