

**South Carolina Department of Social Services**  
**Temporary Assistance for Needy Families (TANF)/Supplemental Nutrition Assistance Program (SNAP)**  
**REQUEST FOR INFORMATION**

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

Case Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

This is to provide you, in writing, the information we must have in order to determine your eligibility for TANF and/or SNAP.

Please provide the information checked below to us by \_\_\_\_\_.

**If you need assistance, contact the Agency at 1-800-616-1309 or visit any DSS county office.**

|   |  |
|---|--|
| <b>Identification</b>                   | <input type="checkbox"/> Proof of your identity<br><input type="checkbox"/> Proof of your residency<br><input type="checkbox"/> Proof of your citizenship status (green card) if you are not a U.S. citizen.<br><input type="checkbox"/> Birth certificates and immunization records for all children. <b>(TANF Only)</b><br><input type="checkbox"/> Marriage license. <b>(TANF Only)</b><br><input type="checkbox"/> Divorce decree or legal separation agreement. <b>(TANF Only)</b>  |
| <b>Resource Information (TANF Only)</b> | <input type="checkbox"/> Your most recent bank statement, credit union statement, CD statement or savings account book to prove how much money you have in any checking or savings account.<br><input type="checkbox"/> Proof of any stock or bonds.<br><input type="checkbox"/> Proof of any property you own.<br><input type="checkbox"/> Registration for all vehicles (autos, motorcycles, boats, recreational vehicles) registered to any member of your household and the pay-off value on any existing vehicle loans.<br><input type="checkbox"/> Proof of prepaid burial contracts for any benefit group member.   |
| <b>Household Income</b>                 | <input type="checkbox"/> Proof of the amount of Social Security benefits (SSA or SSI) and Medicare payment for _____.<br><input type="checkbox"/> Proof of the amount of veteran's benefits (VA) for _____.<br><input type="checkbox"/> Proof of the amount of unemployment compensation benefits (UCB) for _____.<br><input type="checkbox"/> Check stubs or proof of earnings for the past four consecutive weeks between _____ and _____ for any member of your household that works.<br><input type="checkbox"/> If any member of your household is self-employed, provide their most recent tax return or proof of their self-employment earnings from _____.<br><input type="checkbox"/> If the parent of any children in your household does not live with you, provide proof of how much money the parent gives/gave you for four consecutive weeks between _____ and _____.   |
| <b>(Optional) Expenses</b>              | <p>If you fail to provide the verification listed below, you will not be given the deduction. It is not mandatory that you provide the verification but it may help increase your SNAP benefits that which you are eligible.</p> <input type="checkbox"/> Proof of child care expenses.<br><input type="checkbox"/> Proof of the amount billed for rent.<br><input type="checkbox"/> Proof of any housing or utility assistance you may receive.<br><input type="checkbox"/> Proof of your monthly mortgage amount.<br><input type="checkbox"/> Most recent home insurance and property tax bills.<br><input type="checkbox"/> Proof of the following utility bills: <input type="checkbox"/> Electric <input type="checkbox"/> Water <input type="checkbox"/> Heating Bills <input type="checkbox"/> Telephone<br><input type="checkbox"/> Proof of any utility assistance checks.<br><input type="checkbox"/> Proof of court-ordered child support paid outside of the household.<br><input type="checkbox"/> If you are 60 or older, or disabled, and you pay more than \$35 monthly in medical bills, provide proof of all medical expenses for _____. |
| <b>Other</b>                            | <input type="checkbox"/> If the parent of any child in your household does not live with you, provide proof of the parent's Social Security number, address and employer. Any other available information on this individual should be provided to us. <b>(TANF Only)</b><br><input type="checkbox"/> Other: _____   |

DSS Employee: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

This institution is an equal opportunity provider.

DSS Form 1669 (MAR 20) Edition of NOV 17 is obsolete.