

# NOTICE OF EXPIRATION

Your Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) benefits will expire on

To receive SNAP and/or TANF without interruption, you must complete and mail this form along with all proof of information or take to any DSS Office as soon as possible, but must be received by

If you need help with this form, please call 1-800-616-1309.

	DATE RECEIVED – OFFICE ONLY	OFFICE USE ONLY	CO. NO.	CASE NAME
		If submitted late, expedited?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Enough Info.		CASE NUMBER
				SNAP/TANF CERT. THRU DATE

## SECTION 1: Tell Us About Yourself

Last Name:		First Name:			MI:	Suffix:
Home Phone No.:		Cell Phone No.:		Another telephone number where you can be contacted:		Best time to call:
<b>WHERE DO YOU LIVE</b>						
Street Address: (Include Apt./Lot No.)			City:	State:	Zip Code:	County:
Have you moved since your last application or renewal? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>IF YOU RECEIVE YOUR MAIL SOMEPLACE ELSE, PLEASE FILL IN SECTION BELOW.</b>						
Mailing Address: (If Different, Include Apt./Lot No.)			City:	State:	Zip Code:	County:
Is this a new mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No						
I certify that the questions above and below on this form have been answered truthfully and completely under the penalty of perjury. I understand that the information given on this form may cause my SNAP or TANF benefits to stop or change. I give permission for the Department of Social Services to make any necessary contacts to check my statements.						
SIGNATURE: _____				DATE: _____		

## SECTION 2: Tell Us About Your Household Members

List everyone who lives with you. Answer all questions in the table below for each household member. Verification of information about all household members may be required. You only have to provide the SSN or date of SS-5 and citizenship/immigration status of the persons for whom are applying. SSN and citizenship/immigration status is voluntary for non-applicants and ineligible persons in your household.

Name (First, Middle, Last) List names as they appear on the person's Social Security Card.	Relationship to Person on Line 1	Date of Birth	Age	Sex M/F	Hispanic or Latino	Race Code (Choose one or more)	Social Security Number or Date of SS-5	Blind or Disabled	US Citizen	In School	Working	Include in Budget
1.	(Self)				Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
2.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
3.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
4.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
5.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
6.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No
7.					Yes No			Yes No	Yes No	Yes No	Yes No	Yes No

Race: BL - Black or African American; WH - White; AS - Asian; AI - American Indian/Alaskan Native; NH - Native Hawaiian or Other Pacific Islander  
The collection of ethnic and racial information from the applicant is voluntary and will not affect eligibility or the level of benefits the applicant may receive.  
The information is collected to assure that the program benefits are distributed without regard to race, color, or national origin.

1. Is anyone listed above pregnant?  Yes  No  
If yes, who: \_\_\_\_\_ Due date: \_\_\_\_\_
2. Is anyone living in a special setting such as a shelter for battered women and children, homeless shelter, drug or alcohol treatment or rehabilitation facility (DAA), group home for blind or disabled individuals (GLA), or other institution?  Yes  No  
If yes, who: \_\_\_\_\_ Type of Facility: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
3. Is anyone in your household a regular participant in a drug or alcohol program?  Yes  No (If yes, send proof)  
If yes, who: \_\_\_\_\_
4. Does anyone own any cars, trucks, other assets or land/buildings other than where you live?  Yes  No  
If yes, for TANF, what is the value? \$ \_\_\_\_\_
5. How much does the household have in cash \$ \_\_\_\_\_, checking \$ \_\_\_\_\_, and/or savings account(s) \$ \_\_\_\_\_?  
For TANF, please provide the most recent bank account statement.
6. Are you or anyone who lives with you a fleeing felon or probation/parole violator?  Yes  No  
If yes, who: \_\_\_\_\_
7. Have you or anyone who lives with you been found guilty of committing one of the following offenses after August 22, 1996:
  - A drug-related felony?  Yes  No If yes, who: \_\_\_\_\_
  - Receiving TANF (cash benefits) or SNAP benefits from two or more states at the same time?  Yes  No  
If yes, who: \_\_\_\_\_
  - Trading SNAP benefits for drugs?  Yes  No If yes, who: \_\_\_\_\_
  - Buying or selling SNAP benefits over \$500?  Yes  No If yes, who: \_\_\_\_\_
  - Trading SNAP benefits for guns, ammunitions, or explosives?  Yes  No  
If yes, who: \_\_\_\_\_

**SECTION 3: For Temporary Assistance for Needy Families ONLY**

Is there any new information you need to report about the absent parent(s)?  Yes  No

If yes, please complete the table below and list the additional information. If you need more room, attach another sheet of paper with additional information, including absent parent's name(s).

Absent Parent's Name, Last Known Address and Phone Number:		Date of Birth	Social Security No.
Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	
Absent Parent's Name, Last Known Address and Phone Number:		Date of Birth	Social Security No.
Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	

***I do hereby attest under the penalty of perjury that the above information is true and correct to the best of my knowledge and belief and is given for the purpose of receiving services under Title IV-D of the Social Security Act. By signing this DSS Application for Public Assistance, I understand that these assertions are true and will be used in legal pleadings against the absent parent.***

**SECTION 4: Tell Us About Your Household Income**

1. Are you or anyone in your household working?  Yes  No **If yes, send in all paystubs received in the last 4 weeks.** Complete the table below for each household member currently working.

**Note:** If you do not receive payment in the form of money for your work (in-kind or with an established volunteer organization), or just started work and have not received a paystub yet, or if you do not have all paystubs, have the person you work for complete this section.

If employment has ended, please indicate the reason employment ended and the former employer: \_\_\_\_\_

Date of Final Check: \_\_\_\_\_ Gross Amount of Final Check: \$ \_\_\_\_\_

If your employment has ended, have you applied for unemployment?  Yes  No

Name of Person Working:					Name of Person Working:								
Name and Address of Employer:					Name and Address of Employer:								
Telephone Number of Employer:			Fax Number of Employer:		Telephone Number of Employer:			Fax Number of Employer:					
Amount Each Pay Period Before Taxes: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly Hours Worked Each Week: _____					Amount Each Pay Period Before Taxes: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly Hours Worked Each Week: _____								
	DATE PAY RECEIVED			GROSS PAY	TIPS	TOTAL HOURS		DATE PAY RECEIVED			GROSS PAY	TIPS	TOTAL HOURS
	MO	DAY	YEAR					MO	DAY	YEAR			
1.							1.						
2.							2.						
3.							3.						
4.							4.						
Employer Signature _____ Telephone No. _____ Printed Name: _____						Employer Signature _____ Telephone No. _____ Printed Name: _____							

2. **Is anyone in your household, aged 18-49, unable to work?**  Yes  No  
If yes, who: \_\_\_\_\_ Why is this person unable to work? \_\_\_\_\_

3. Do you or anyone who lives with you get money other than from work?  Yes  No  
If yes, complete the table below.

OTHER INCOME	AMOUNT	HOW OFTEN DO YOU GET THIS INCOME?	WHO GETS THIS INCOME?
Child Support (Voluntary or Court Ordered)	\$		
SSI	\$		
Social Security Benefits	\$		
Unemployment Benefits	\$		
Veterans Benefits	\$		
Other: (Explain)	\$		

**SECTION 5: Tell Us About Your Household Expenses**

Please tell us about any expenses that you or anyone who lives with you pays for and send proof of the expenses.

ITEM	WHO PAYS?	AMOUNT	ITEM	WHO PAYS?	AMOUNT
Rent		\$	Mortgage		\$
Condominium Fees		\$	2nd Mortgage		\$
Name of Landlord:			Land Payment		\$
Telephone No. of Landlord:			Property Taxes/Assessments Not Included In House Payments		\$
Mobile Home Rental Space/Lot		\$	Homeowner's Insurance Not Included In House Payments		\$

1. Do you pay to heat or cool your home?  Yes  No  
If yes, how do you heat or cool your home? \_\_\_\_\_
2. Does your household receive LIHEAP (Low-Income Home Energy Assistance Program) payments?  Yes  No  
If you answered NO to both of the questions above, what is the amount of your monthly utilities other than phone?  
\$ \_\_\_\_\_
3. Does any person pay for child care, or pay for the care of a disabled adult household member?  Yes  No  
Send all bills and/or receipts for the dependent care and complete the information below for that month.

Who does the sitter care for?:	Who pays the sitter?:
Name of Sitter:	
Cost:	How often?:
If you do not have all bills/receipts, have sitter complete this section:	
Sitter's Signature:	Phone No. of Sitter:
Do you receive an SC Voucher? (Formerly ABC Child Care Voucher) <input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Does anyone in your household pay child support?  Yes  No  
If yes, how much? \$ \_\_\_\_\_ How often? \_\_\_\_\_ Is it court ordered?  Yes  No
5. If anyone in your household is disabled or over 60, does he/she have new out of pocket medical expenses over \$35 each month (obtained since your last application/recertification)?  Yes  No **If yes, please send proof.**

**SNAP Warnings and Penalties**

- **DO NOT buy ineligible items such as alcoholic beverages or tobacco with SNAP benefits.**
- **DO NOT use your EBT card to pay for food charged to a credit account.**
- **Violators of the above rules may not be able to get SNAP benefits for a period of 1 year to permanently and may be fined up to \$250,000 or imprisoned up to 20 years or both. A court can also add an additional 18-month SNAP participation restriction for an individual.**
- **DO NOT buy or sell firearms, ammunition or explosives with SNAP benefits; if you do, you can never get SNAP benefits again.**
- **DO NOT buy or sell illegal drugs with SNAP benefits; DO NOT trade, sell or alter Electronic Benefit (EBT) cards; if you do, you cannot get SNAP benefits for 24 months for the 1<sup>st</sup> offense and permanently for the 2<sup>nd</sup> offense.**
- **DO NOT trade, sell or share EBT cards or SNAP benefits. If a court of law finds you guilty of selling benefits of \$500 or more, you will be permanently ineligible to participate in the program for the first offense.**
- **DO NOT receive SNAP benefits in more than one state for the same month. Any individual found to have made a fraudulent statement, or fraudulent representation of identity or residence in order to receive benefits shall be ineligible to receive SNAP benefits for 10 years.**
- **Any member of your Household who intentionally breaks the rules may not get SNAP for 12 months for the first offense, 24 months for the second offense and permanently for the third offense.**

South Carolina Department of Social Services  
**VOTER PREFERENCE FORM**

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

(Please check one)

- Yes**, I would like to register to vote.
- I am registered, but **not** at my **current** address.
- No**, I am registered at my **current** address.
- No**, but I will use the Voter Registration Mail Application.
- No**. I do not wish to register to vote at this time.
- No**. I am not eligible to vote.
- No**. I am refusing to register.

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

\_\_\_\_\_  
Signature of Applicant/Declinee

\_\_\_\_\_  
Date

**Important Notices**

- 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 preference or other political preference, you may file a complaint with the following: Executive Director at South Carolina Election Commission, 1122 Lady St. Suite 500, P.O. Box 5987 Columbia, SC 29205 or call 803-734-9060, fax to 803-734-9366, or email [elections@elections.sc.gov](mailto:elections@elections.sc.gov). This address is for complaints only regarding your right to vote.
- If you would like help in filling out the voter registration application, we will help you. The decision whether to seek or accept help is yours. For assistance in completing the voter registration application form outside our office, call 1-800-616-1309.
- 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 do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

**RETURN FORMS TO DSS:**

South Carolina Department of Social Services  
Centralized Scan Center  
P.O. Box 100203  
Columbia, SC 29202-3203



### Renewal/Redetermination Form

This form will be considered filed as long as it contains a legible name, address, and signature.

- Answer all questions on this form. If you do not have enough space on the form for your answers you may attach an additional sheet of paper.
- You have the right to receive an application form upon request.
- Forms received after the due date, or without the requested proof, will be considered late/incomplete and may delay your SNAP/TANF benefits for the following month. If you need help in getting the requested proof, call the telephone number on the first page of this form.
- Failure to report or verify any deductible expenses will be seen as a statement that your household does not want to receive a deduction for the expense.
- If a large letter "A" or "C" is listed on the top of the first page of this form, then benefits will not be issued without an interview. You will receive a letter in the mail with instructions on completing your interview after you file this form with DSS. Failure to complete your interview may result in a delay or denial of benefits.
- The information that you give to DSS will be kept confidential. However, the information may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending fleeing felons or probation/parole violators. You agree that confidential information about you and/or your family may be released to other organizations if it is directly related to the operation of TANF and/or SNAP.
- DSS does not share Social Security Numbers (SSNs) or citizenship/immigration status for non-applicants and individuals ineligible for benefits with the US Department of Homeland Security.
- DSS will use SSNs in the state income and eligibility verification system and other computer matching and program reviews. This information may be verified through other sources when discrepancies are found and may also affect your household's eligibility and benefit level. This information, including the Social Security Number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008. This information will also be used to monitor compliance with program regulations and for program management. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible members.
- You have a right to an appeal and to request a fair hearing. If you disagree with the benefits you get from us, or if your benefits have been denied or stopped, you can ask for a Fair Hearing. You may speak for yourself at the hearing. You may also bring a friend, relative, or lawyer to speak for you. At a Fair Hearing both you and DSS will tell a Hearing Officer what has happened in your case. The Office of Administrative Hearings will then send you a decision on your case.
- The ePAY card should not be used in any electronic transaction:
  - In any liquor store;
  - Casino, gambling casino or gaming establishment; or
  - Retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

### Report Changes

- You must report certain changes in your circumstances to DSS.
- Your failure to report changes is considered to be withholding of information and will permit DSS to recover any benefits paid to you in error.
- You may report in writing, by phone, electronically or by use of the Change Report Form to report changes between recertification/redeterminations.

### SNAP

For households who are required to recertify every six months, you must report when your total gross income exceeds 130 % of the federal poverty level, when an ABAWD in your SNAP household is no longer meeting the work requirement hours, or when a member of your household wins lottery or gambling winnings equal to or greater than \$3500 from a single game before taxes or other withholdings. These changes must be reported by the tenth day of the month after the month of the change. All other changes must be reported at recertification.

### Temporary Assistance for Needy Families Program (TANF) and Refugee Cash Assistance Program (RCA)

Report these changes within **10 days**:

- Change in any income, hours of employment, rate of pay or new source of income, change in your address or residence, person(s) moving in or out of your home.

Report this change within **5 days**:

- Any household member temporarily living away from the household who has decided not to return to the household.

### Non-Discrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: [http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You may also file a complaint of discrimination by contacting DSS. Write DSS Office of Civil Rights, P.O. Box 1520, Columbia, SC 29202-1520; or call (800) 331-7220 or (803) 898-8080 or TTY: (800) 311-7219.