GENESEE CO DHS UNION ST DISTRICT
PO BOX 1615
FLINT MI 48501

Save time - go online!
Go to www.michigan.gov/mibridges/ to
access your case online, or call (888) 642-7434.

Case Name: **Jason Schmidt**
Case Number: **134840347**
Date: **02/15/2024**
MDHHS Office: **GENESEE CO DHS UNION ST DISTRICT**

Specialist: **M. Client-connection**
Phone: **(844) 464-3447**
Fax: **(517) 346-9888**
Specialist ID: **MDHHS-Genesee-Union**

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area.
MDHHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de MDHHS en su área.
La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب MDHHS الموجود في منطقتك.
يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

JASON SCHMIDT
40 13 COLONIES LN
FLINT MI 48507

GENESEE CO DHS UNION ST DISTRICT
PO BOX 1615
FLINT MI 48501

NOTICE OF CASE ACTION

Please read each page of this notice carefully.

We have reviewed your application or case. The actions that affect your case are listed in this notice.

Benefit Summary

(more information about your benefits follows this summary)

FOOD ASSISTANCE PROGRAM

Period	Action	Benefit	Household Size
02/02/2024 - 02/29/2024	Approved	$ 237.00/mo.	1
03/01/2024 - 01/31/2026	Approved	$ 246.00/mo.	1

More Information About Benefits

Food Assistance Program Details

Food Assistance Application Date: 02/02/2024

For the month(s) of:	Benefits are:	Amount	Who's Included
02/02/2024 - 02/29/2024	APPROVED	$ 237.00/mo.	Jason Schmidt
03/01/2024 - 01/31/2026	APPROVED	$ 246.00/mo.	Jason Schmidt

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If approved for cash assistance, your benefits may go down or stop.

Your monthly income is based on your total income and expenses. Your expenses do not reduce your income dollar for dollar. The following amounts were used to determine your benefits:

Monthly Income (after deductions)	$ 150.00

BUDGET SUMMARY	
Earned Income	0.00
Self Employment Income	0.00
Unearned Income	1600.00
Standard Deduction	198.00
Homeless Shelter Deduction	0.00
Medical Expenses	165.00
Dependent Care	0.00
Child Support Payments	0.00
Housing Costs	1025.00
Heat/Utility Standard (including phone)	680.00
Non-Heat Electric Standard	0.00
Water/Sewer Standard	0.00
Telephone Standard	0.00
Cooking Fuel Standard	0.00
Trash Standard	0.00
Benefits Withheld to Repay an Overissuance	0.00

Your Food Assistance Program benefits will be deposited to your food account on the Michigan Bridge Card based on the last number in your grantee id. Your grantee ID is 1281390355.

EBT BENEFIT DEPOSIT DATE FOR FOOD ASSISTANCE PROGRAM
Last Digit of Grantee ID is: 5
Food Benefits are available on this day each month: 13

Please Note: Benefits are available on the date shown above and any time after that date.

HEARING RIGHTS

You have the right to request a hearing if you do not agree with any action or decision the department makes (including failure to act with reasonable promptness). You can ask for a hearing for FAP by phone. Hearings for all other programs must be requested in writing. At the hearing you can explain why you disagree with the action or decision and present evidence.

The request should include your name, address and case number. Attach a copy of this notice if possible. Go to www.michigan.gov/documents/FIA-Pub18_14356_7.pdf to download a form to use or contact local MDHHS office shown on the first page of this notice to request a form.

- Keep a copy of the request and any other document you attach for yourself.
- MDHHS must receive your request for appeal within 90 days of the mailing date of this notice. Your request must be received on or before 05/15/2024 or you will not be granted a hearing.
- MDHHS must receive your request for an appeal within 10 days of the mailing date of this notice to continue receiving your benefits. Return your request on or before 02/26/2024.

You may be required to repay any assistance that you receive while your appeal is pending if 1) the department's proposed action is upheld in the hearing decision, or 2) your request for appeal is withdrawn, or 3) you or your authorized representative do not attend this hearing.

You may choose anyone to represent you. If that person is not a lawyer or is not appointed by a court, you must give us your signed authorization. Attach a copy of the court's order if the person is court appointed to help you. The Michigan Administrative Hearing System (MAHS) will deny the request for an administrative hearing made by the representative if you do not provide proof of authorization. The authorized hearing representative needs to be authorized before they can make the request.

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, 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

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(3) email: 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/.

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.

The Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a MDHHS office in your area.

Important Information - Please Read

MiBridges Client Self-Service

The Michigan Department of Health and Human Services offers two client self-service options:

* Applicants and recipients can obtain information about their case, review benefits and report changes directly to their MDHHS specialist on-line by visiting www.michigan.gov/mibridges.
* In addition, case information can be obtained 24 hours a day by calling the automated information line at 1-888-MiBridges (642-7434).

Reporting Changes

If you receive benefits for a cash assistance program, food assistance program, or child care it is your responsibility (or that of the person acting for you) to notify this office within 10 days of any changes in your circumstances which may affect your eligibility for assistance. This includes changes in employment, income, assets and health insurance premiums for you or members of your family, the number of persons living in your home, college student status, and change of address. Failure to report changes may make you liable to penalties provided by law for fraud. Your MDHHS specialist will tell you if different reporting rules apply to you, such as simplified reporting.

Free School Meals

School-aged children who get FIP and/or FAP can also get free school meals if the school participates in the U.S. Department of Agriculture National School Lunch Program. Show this notice (Notice of Case Action) to school officials to verify your eligibility when asked, or to apply for free school meals.

WIC (Women, Infants, and Children)

If you are pregnant, recently had a baby or have children under the age of 5, your household may be eligible for WIC. Contact your local health department or call 1-800-942-1636 for more information.

Domestic Violence

You are authorized to receive domestic violence comprehensive services. Contact the MDHHS office in your area or your MDHHS specialist for more information. To access these services visit www.michigan.gov/domesticviolence, or www.michigan.gov/dhs-publications to view MDHHS Publication-859, Is someone hurting you or your children?

Bridge Card Information

After you receive your first replacement card, your benefits may be reduced to cover the cost of replacing any additional cards.

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Case Number: **134840347**
Date: **02/15/2024**
MDHHS Office: **GENESEE CO DHS UNION ST DISTRICT**

Specialist / ID: **M. Client-connection / MDHHS-Genesee-Union**
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Individual ID: **1281390355**

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JASON SCHMIDT
40 13 COLONIES LN
FLINT MI 48507

GENESEE CO DHS UNION ST DISTRICT
PO BOX 8123
ROYAL OAK MI 48068-9985

CHANGE REPORT

Use this form to **report changes about anyone in your home within 10 days** of the time you learn of them (For earned income, within 10 days of receiving of your first payment.) If you cannot mail this form, report the change by calling your MDHHS specialist.

1. PERSONS IN YOUR HOME

List anyone who:
- Was Born--Enter newborn's date of birth _____
- Died
- Got Married or Divorced
- Moved In or Out
- Began or Ended a Pregnancy
- Entered or Left a Nursing Home
- Is Temporarily Away From Your Home.

PERSON'S NAME	RELATIONSHIP TO YOU	DATE OF BIRTH	WHAT WAS THE CHANGE?	DATE OF CHANGE

2. HOUSEHOLD INCOME

Did anyone: start working, have a change in rate of pay, change employers, have a change in the number of hours worked per week of more than 5 hours since last report that will continue for more than one month, stop working? **Did anyone:** start or stop getting Social Security, a pension, UCB, child support or other unearned income. Did the household's gross unearned income go up or down by more than $50 per month since your last reported change? If receiving Medicaid only (except for Healthy Kids), you must report a change in gross monthly unearned income of more than $25.

ATTACH a written statement SIGNED BY EMPLOYER, listing your work schedule (days and times) if you use day care and your work schedule has changed.

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Case Name	Case Number	Specialist
Jason Schmidt	134840347	M. Client-connection / MDHHS-Genesee-Union

SEND PROOF OF INCOME: Include your name and case number on it so we may return it to you.

PERSON WITH INCOME CHANGE	TYPE OF INCOME	DID INCOME START, STOP OR CHANGE?	IS THE CHANGE EXPECTED TO CONTINUE? (Yes/No)	NUMBER OF EXPECTED HOURS OF WORK PER WEEK	HAS WORK SCHEDULE CHANGED?	AMOUNT RECEIVED?	HOW OFTEN IS INCOME RECEIVED? (Weekly, Bi-Weekly, Monthly, etc.)

3. EDUCATION OR WORK-RELATED ACTIVITIES

Did anyone participate in an approved employment-related activity, such as: a work participation program, high school completion, GED or college, etc. **ATTACH NEW CLASS SCHEDULE TO THIS FORM IF CHANGED.**

LIST PERSON IN ACTIVITY	TYPE OF ACTIVITY	HAS CLASS SCHEDULE CHANGED? (Yes/No)	DID ACTIVITY START, STOP, OR CHANGE?	NUMBER OF HOURS OF EXPECTED PARTICIPATION PER WEEK

4. CHILD DAY CARE OR DISABLED ADULT CARE

Report any need for or change in child or disabled adult care such as changes in: need, days and times care is provided, provider changes, where care is provided, provider charges, etc. Do you receive help to pay for this care? ____ Yes ____ No

PERSON RECEIVING CARE	AGE	REASON FOR CARE(Work, School, Training, Medical/Social)	DATE OF CHANGE?	NAME OF THE PROVIDER	PROVIDER ID NUMBER
a.					
b.					
c.					
d.					

PERSON RECEIVING CARE (List the same person as above)	DAYS AND TIMES CARE IS PROVIDED	IS CARE PROVIDED IN CHILD'S HOME?	IS PROVIDER RELATED TO THE CHILD	RATE CHARGED AND HOW OFTEN (Hourly, Daily, Weekly, etc.)	
a.				$	per
b.				$	per
c.				$	per
d.				$	per

Case Name	Case Number	Specialist
Jason Schmidt	134840347	M. Client-connection / MDHHS-Genesee-

5. ASSETS

Report if anyone has opened or closed any accounts such as: bank, retirement or CD, or bought, sold, transferred, given away, or received any other asset such as: land, cars, and other vehicles, boats, life insurance, investments, lawsuit settlements or any other property.

WHAT CHANGED?	PLEASE EXPLAIN THE CHANGE

6. OTHER CHANGES

Report if anyone has a change such as: address, rent, mortgage, taxes, insurance (home or health), utility costs, child support paid, medical expenses, school attendance.

PERSON WITH CHANGE	DATE OF CHANGE	PLEASE EXPLAIN THE CHANGE

7. Do you expect the changes you reported to continue next month?

☐ Yes ☐ No If no, please explain below.

I understand that the information I provide on this report form may result in changes in my assistance, including reducing the amount of my checks (Cash Assistance, employment-related services and/or Child Development and Care), Food Assistance benefits and medical assistance, or closing my case. I understand that such changes may be made without advance notice. **I am aware that, if I give false information which causes me to receive assistance I am not entitled to, or more assistance than I am entitled to, I can be prosecuted for fraud.** I must report all changes in my situation within 10 days of learning of the change, or for earned income, within 10 days of the start date of employment.

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Client's Signature or Mark	Date	Client's Telephone Number
Signature of Other Person Completing Form or Witness		Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Act 280 of 1939, Food Stamp Act of 1977 **COMPLETION:** Voluntary
PENALTY: Loss of eligibility for assistance benefits

This institution is an equal opportunity provider.

DHS-2240 (Rev. 6-19) Bridges

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