ARKANSAS DEPARTMENT OF HUMAN SERVICES

Benefit Verification Worksheet

Head of Household's name: Kathryn Scott Date of request: 06-06-22

Date of birth: 09/16/1996

Household member 1: Kathryn Scott Date of birth: 09/16/1996

Please check the appropriate box that corresponds to the benefit program that the above named recipient is currently receiving:

☒ SNAP - Please provide end date if case is closed: _____. SNAP Monthly Benefit Amount: $649

☒ TEA - Please provide end date if case is closed: _____

☐ Arkansas Works - Please provide end date if case is closed: _____

☐ Medicaid (This includes ARKids) - Please provide end date if case is closed: _____

Household member 2: Stellen Scott Date of birth: 03/04/1994

Please check the appropriate box that corresponds to the benefit program that the above named recipient is currently receiving:

☒ SNAP - Please provide end date if case is closed: _____ SNAP Monthly Benefit Amount: $_____

☒ TEA - Please provide end date if case is closed: _____

☐ Arkansas Works - Please provide end date if case is closed: _____

☐ Medicaid (This includes ARKids) - Please provide end date if case is closed: _____

Household member 3: Leon Scott Date of birth: 11/29/2021

Please check the appropriate box that corresponds to the benefit program that the above named recipient is currently receiving:

☒ SNAP - Please provide end date if case is closed: _____ SNAP Monthly Benefit Amount: $_____

☒ TEA - Please provide end date if case is closed: _____

☐ Arkansas Works - Please provide end date if case is closed: _____

☐ Medicaid (This includes ARKids) - Please provide end date if case is closed: _____

** NOTE: For each additional household member, please attach another worksheet**

Signature of County Office Representative: MSparks Date: 06062022

Scott County DHS
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