



Your Texas Benefits: Form

Please use dark ink. Please print. If you need more room, add pages.

Fill in the circles (○) like this → ●

Section A

Your Facts

If you're applying to get SNAP food benefits, the first month's amount will be based on the date we get pages 1 and 2.

Other benefits also are based on when we get pages 1 and 2.

If you send only pages 1 and 2 now, you will still need to fill out the rest of the application to get benefits.

You have the right to file this form immediately if it has your name, address, and signature.

Mark the benefits anyone on your case is applying for:



☒ SNAP Food Benefits

☐ TSAP Food Benefits



☐ TANF Cash Help for Families



Health-care benefits:

☐ Children ☐ Adult caring for a Child

☒ Adult not caring for a Child

☐ Pregnant Woman

Person 1: contact person or head of household

Vincent

Stolden

First name

Middle name

Last name

4 5 9 - 8 1 - 0 5 1 4

Social Security number

0 1 / 1 4 / 1 9 8 7

Birth date (month/day/year)

2401 Colt Ln

Mailing address

Crowley

Texas

76036

City

State

ZIP

(817) 851-4526

(817) 851-4526

Home phone

Cell or daytime phone

2401 Colt Ln

Tarrant

Home address

County

Crowley

Texas

76036

City

State

ZIP

Section B

SNAP Food Benefits

This section is only for people applying for SNAP food benefits.



Find out how to return your form: See page 3.

You might be able to get SNAP food benefits the next work day if you:

- Are a migrant or seasonal farm worker,
- Have \$100 or less in available cash and bank accounts and expect to earn less than \$150 this month, or
- Have costs for housing or utilities that are more than your cash, bank accounts and the income you expect for the month.

Answer them for everyone living in your home.

1. Is anyone in the home a migrant worker or a seasonal farm worker? ☐ Yes ☒ No

2. Does anyone in the home have money in the bank or cash? ☐ Yes ☒ No

\$

Amount

3. Does anyone in the home expect to receive money this month? (This includes money you get from jobs, child support, social security, and unemployment) ☐ Yes ☒ No

\$

Amount

4. Does anyone in the home pay costs for housing and utilities? (This includes rent, mortgage, water, gas, electric, sewage, trash, phone and property tax.) ☐ Yes ☒ No

\$

Amount

I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

Signed online: Vincent Stolden

Sign here (or have someone with the right to act for you sign)

11/08/2023

Date



More on page 2





Section C

Pregnant Women

This section is only for people applying for health-care benefits.



Is anyone in your home pregnant? ☐ Yes ☐ No



If yes, who?

Number of babies expected

Is this your first pregnancy? ☐ Yes ☐ No

Due date

				/				/				
--	--	--	--	---	--	--	--	---	--	--	--	--

What is the first and last name of the unborn child's father?

First name										Last name									

Was anyone in your home pregnant during the last 12 months? ☐ Yes ☐ No



If yes, who?

When did the pregnancy end?

				/				/				
--	--	--	--	---	--	--	--	---	--	--	--	--

Section D

Military Service

This section is only for people applying for health-care benefits.



Is anyone an active duty member of one of these military forces?

- U.S. Armed Forces
- National Guard
- Reserves
- State Military Forces

..... ☐ Yes ☒ No



If yes, who?

Social security number:

4	5	9	-	8	1	-	0	5	1	4
---	---	---	---	---	---	---	---	---	---	---



Section E

Interview Help

1. Most people applying for benefits must be interviewed.
We often interview people on the phone.

It helps to know if any of the reasons below make it hard for you to get to a benefits office:

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• You live more than 30 miles from the closest benefits office.• You can't get a ride.• The weather is bad.• You are sick. | <ul style="list-style-type: none">• Your work or training hours don't allow you to get to a benefits office when it's open.• You can't travel because you are age 60 or older, or you have a disability. | <ul style="list-style-type: none">• You are a victim of family violence.• You take care of someone in your home. |
|---|---|---|

Do any of the reasons above apply to you? ☐ Yes ☒ No

2. If you come to our office, will you need special help or equipment? ☐ Yes ☒ No

If yes, what do you need?

3. What language do you want to speak during the interview? English

4. Will you need an interpreter? We can get one for you for free. ☐ Yes ☒ No
If yes, mark the one you need:


- ☐ Spanish ☐ Vietnamese
☐ American Sign Language ☐ Other: _____

Social security number:

4 5 9 - 8 1 - 0 5 1 4



Your Texas Benefits: Form

Fill in the circles (☐) like this 
Please use dark ink. Please print. If you need more room, add pages.

Section F Contacting You

Person 1: Contact Person or Head of Household

Vincent Stolden
First name Middle name Last name

4 5 9 - 8 1 - 0 5 1 4
Social Security number

0 1 / 1 4 / 1 9 8 7
Birth date (month/day/year)

Vincent.stolden3@gmail.com
E-mail

Are you applying for benefits for yourself or a child? ☒ Yes ☐ No

If yes, give your facts below:

Section G

Person 1

Person 1

If you get money from Social Security or railroad retirement, list the number you have:

Social Security claim number

Railroad retirement number

☐ Married ☒ Single ☐ Divorced
☐ Separated ☐ Widowed

Live in Texas? ☒ Yes ☐ No

Plan to stay in Texas? ☒ Yes ☐ No

Optional Questions

☒ Male ☐ Female

Hispanic or Latino? ☐ Yes ☒ No

Mark one or more:

☒ Black or African-American

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Pacific Islander

☐ White

Are you going to school? ☐ Yes ☒ No

If yes, are you going full-time? ☐ Yes ☐ No

Are you a U.S. citizen? If no, give facts below. ☒ Yes ☐ No

Are you a refugee or legally admitted immigrant? ☐ Yes ☐ No

If you have a sponsor, write your sponsor's name

Date you entered the U.S. (month/day/year)

Are you registered with the U.S. Citizenship and Immigration Services? ☐ Yes ☐ No

Immigrant registration number

Women 15-44 years old who do not qualify for Medicaid or CHIP are automatically tested for Healthy Texas Women (HTW) eligibility. Check the box below if you waive HTW testing.

☐ I do not want to be tested for HTW

Return this completed form by fax, mail, or in person:

Fax: 1-877-447-2839

Mail: HHSC, PO Box 149024
Austin, TX 78714-9968

In person: Call 2-1-1 to find an HHSC benefits office near you.

Use pages 4 and 5 for other people applying for benefits.

If you need more pages, you can:

- Add a blank page and write in your facts.

OR

- Go to www.hhsc.state.tx.us to get an extra page.

Click on "How to Get Help."





Section H

People Applying for Benefits

Mark the benefits Person is applying for:

- ☐ SNAP Food Benefits
☐ TSAP Food Benefits

TANF Cash Help for Families:

- ☐ TANF
☐ One-Time TANF
☐ One-Time TANF for Relatives

Health-care benefits for:

- ☐ Children
☐ Adult Caring for a Child
☐ Adult not caring for a Child
☐ Pregnant Woman

Person 2: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name

Middle name

Last name

- -

Social Security number

/ /

Birth date (month/day/year)

This person's relationship to you If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # Railroad retirement #
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Live in Texas? ☐ Yes ☐ No
Plan to stay in Texas? ☐ Yes ☐ No

Optional Questions

☐ Male ☐ Female Hispanic or Latino? ☐ Yes ☐ No

Mark one or more:

☐ American Indian or Alaska Native ☐ Asian
☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ White

Is this person going to school? ☐ Yes ☐ No If yes, is this person going full-time? ☐ Yes ☐ No

Is this person a U.S. citizen? If no, give facts below. ☐ Yes ☐ No

Is this person a refugee or legally admitted immigrant? ☐ Yes ☐ No

/ /

If this person has a sponsor, write the sponsor's name

Date you entered the U.S. (month/day/year)

Is this person registered with the U.S.

Citizenship and Immigration Services? ... ☐ Yes ☐ No

Immigrant registration number

☐ I do not want to be tested for HTW

Person 3: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name

Middle name

Last name

- -

Social Security number

/ /

Birth date (month/day/year)

This person's relationship to you If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # Railroad retirement #
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Live in Texas? ☐ Yes ☐ No
Plan to stay in Texas? ☐ Yes ☐ No

Optional Questions

☐ Male ☐ Female Hispanic or Latino? ☐ Yes ☐ No

Mark one or more:

☐ American Indian or Alaska Native ☐ Asian
☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ White

Is this person going to school? ☐ Yes ☐ No If yes, is this person going full-time? ☐ Yes ☐ No

Is this person a U.S. citizen? If no, give facts below. ☐ Yes ☐ No

Is this person a refugee or legally admitted immigrant? ☐ Yes ☐ No

/ /

If this person has a sponsor, write the sponsor's name

Date you entered the U.S. (month/day/year)

Is this person registered with the U.S.

Citizenship and Immigration Services? ... ☐ Yes ☐ No

Immigrant registration number

☐ I do not want to be tested for HTW





Section H

People Applying for Benefits

Mark the benefits Person is applying for:

- ☐ SNAP Food Benefits
☐ TSAP Food Benefits

TANF Cash Help for Families:

- ☐ TANF
☐ One-Time TANF
☐ One-Time TANF for Relatives

Health-care benefits for:

- ☐ Children
☐ Adult Caring for a Child
☐ Adult not caring for a Child
☐ Pregnant Woman

Person 4: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name

Middle name

Last name

- -

Social Security number

/ /

Birth date (month/day/year)

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here:

Social Security claim #

Railroad retirement #

☐ Married

☐ Single

☐ Divorced

Live in Texas?

☐ Yes ☐ No

☐ Separated

☐ Widowed

Plan to stay in Texas?

☐ Yes ☐ No

Optional Questions

☐ Male ☐ Female

Hispanic or Latino?

☐ Yes ☐ No

Mark one or more:

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African-American

☐ Native Hawaiian or Pacific Islander

☐ White

Is this person going to school? ☐ Yes ☐ No

If yes, is this person going full-time? ☐ Yes ☐ No

Is this person a U.S. citizen? If no, give facts below.

☐ Yes ☐ No

Is this person a refugee or legally admitted immigrant?

☐ Yes ☐ No

/ /

If this person has a sponsor, write the sponsor's name

Date you entered the U.S. (month/day/year)

Is this person registered with the U.S.

Citizenship and Immigration Services? ... ☐ Yes ☐ No

Immigrant registration number

☐ I do not want to be tested for HTW

Person 5: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name

Middle name

Last name

- -

Social Security number

/ /

Birth date (month/day/year)

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here:

Social Security claim #

Railroad retirement #

☐ Married

☐ Single

☐ Divorced

Live in Texas?

☐ Yes ☐ No

☐ Separated

☐ Widowed

Plan to stay in Texas?

☐ Yes ☐ No

Optional Questions

☐ Male ☐ Female

Hispanic or Latino?

☐ Yes ☐ No

Mark one or more:

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African-American

☐ Native Hawaiian or Pacific Islander

☐ White

Is this person going to school? ☐ Yes ☐ No

If yes, is this person going full-time? ☐ Yes ☐ No

Is this person a U.S. citizen? If no, give facts below.

☐ Yes ☐ No

Is this person a refugee or legally admitted immigrant?

☐ Yes ☐ No

/ /

If this person has a sponsor, write the sponsor's name

Date you entered the U.S. (month/day/year)

Is this person registered with the U.S.

Citizenship and Immigration Services? ... ☐ Yes ☐ No

Immigrant registration number

☐ I do not want to be tested for HTW





Section I

More Facts About Children Age 18 or Younger

This section is
only for children
applying for TANF
cash help for
families.



Time Saving Tip

You only need to give
facts for each father
and mother one time.

If a child has the same
mother or father as
another child, you can
write something like
"same as 1st child"
where the parent's
name would go.

Are you afraid that giving facts about the child's other parent might put you or your children in danger?

You might not have to
help or cooperate with
the Office of Attorney
General to collect child
or medical support if you
are afraid. You can ask
not to give these facts by:

- Telling your benefits
advisor (or designated
representative) reasons
why this might put
you or your children
in danger.
- Signing the Good
Cause request form.
(Your benefits advisor
has this form.)

1st child's name:

FATHER

Father's first and last name

Father's birth date

Father's Social Security number

Father's phone

Father's mailing address

City

State

ZIP

Father is: ☐ In home ☐ Out of home ☐ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date

Mother's mailing address

City

State

ZIP

Mother's phone

Employer

Mother is: ☐ In home ☐ Out of home ☐ Deceased

Were these parents ever married to each other? ☐ Yes ☐ No

2nd child's name:

FATHER

Father's first and last name

Father's birth date

Father's Social Security number

Father's phone

Father's mailing address

City

State

ZIP

Father is: ☐ In home ☐ Out of home ☐ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date

Mother's mailing address

City

State

ZIP

Mother's phone

Employer

Mother is: ☐ In home ☐ Out of home ☐ Deceased

Were these parents ever married to each other? ☐ Yes ☐ No





Section I

More Facts About Children Age 18 or Younger (continued)

Are you afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child?

If yes, you might not have to give us facts about that person. You might be able to get the "Family Violence Exemption."

3rd child's name:

FATHER

Father's first and last name

Father's birth date

Father's Social Security number

Father's phone

Father's mailing address

City

State

ZIP

Father is: ☐ In home ☐ Out of home ☐ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date

Mother's mailing address

City

State

ZIP

Mother's phone

Employer

Mother is: ☐ In home ☐ Out of home ☐ Deceased

Were these parents ever married to each other? ☐ Yes ☐ No

4th child's name:

FATHER

Father's first and last name

Father's birth date

Father's Social Security number

Father's phone

Father's mailing address

City

State

ZIP

Father is: ☐ In home ☐ Out of home ☐ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date

Mother's mailing address

City

State

ZIP

Mother's phone

Employer

Mother is: ☐ In home ☐ Out of home ☐ Deceased

Were these parents ever married to each other? ☐ Yes ☐ No



Section J

Other People in the Home

Other people in the home

These people live in my home, but they don't want to apply for benefits.

(Parents living with a child age 18 or younger who is applying or a spouse of a person applying should not be listed here—they should fill out a box in Section H.)

List the birth date only if the person is your relative.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Relationship to you	Birth date (if relative)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Relationship to you	Birth date (if relative)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Relationship to you	Birth date (if relative)

Section K

Help Us Serve You Better

This section is only for people applying for health-care benefits.



These questions will **not** be used to decide if your family can get benefits.

Information about people applying for benefits

1. Does a child applying for health care travel with a family member who is a migrant farm worker? ☐ Yes ☒ No

2. Is a child in the Children with Special Health Care Needs program? ☐ Yes ☒ No

If yes, who?

3. Is anyone an American Indian or Native Alaskan? ☐ Yes ☐ No

If yes, who?

What tribe?

Section L

Other Facts

Other Facts

1. Does anyone have a disability? ☐ Yes ☒ No

If yes, who?

2. Is anyone getting TANF cash help for families, SNAP food benefits or health-care benefits from another state? ☐ Yes ☒ No

If yes, who?

Which state?

When did that person last get benefits?

Social security number:

4	5	9	-	8	1	-	0	5	1	4
---	---	---	---	---	---	---	---	---	---	---



Section L

Other Facts (continued)

Answer 3, 4 and 5
only if anyone
is applying for
TANF cash help for
families or SNAP
food benefits.



3. Has anyone been convicted of a felony that:

(1) took place after August 22, 1996, and (2) involved illegal drugs? ☐ Yes ☒ No



If yes, who?

4. Is anyone living in a place of care such as:

• A homeless shelter • A drug treatment center
• A family violence shelter • A group home ☐ Yes ☐ No



If yes, who?

5. When people break program rules, they are sometimes "disqualified" from getting benefits.

People who are disqualified are sent a letter and told they can't get TANF cash help for families or SNAP food benefits.

Is anyone living with you disqualified from getting TANF cash help for families or SNAP food benefits anywhere in the United States? ☐ Yes ☒ No

Section M

Medical Facts

This section is
only for people
applying for TANF
cash help for
families or
health-care benefits.



Other health insurance

Does anyone have health insurance other than Medicare, Medicaid, or CHIP? ☒ Yes ☐ No

If yes, give facts below.



Vincent Stolden

Cigna

Name of insured person (first, middle, last)

Insurance company

0014865237

08/01/2023

12/31/2023

Policy number

Coverage start date

Coverage end date

Type of coverage \$ 0.00

How much is your premium?

Who pays the premium?

Reason coverage ended

\$ 0.00

Amount you pay each month to cover your children on this insurance

Name of insured person (first, middle, last)

Insurance company

Policy number

Coverage start date

Coverage end date

Type of coverage \$

How much is your premium?

Who pays the premium?

Reason coverage ended

\$

Amount you pay each month to cover your children on this insurance.

Social security number:

4 5 9 - 8 1 - 0 5 1 4



Section M

Medical Facts (continued)

This section is
only for people
applying for TANF
cash help for
families or
health-care benefits.



Medical bills from the past 3 months

If anyone on your case can't pay their medical bills, Medicaid might pay them.

- The bills must be for services they got in the past 3 months.
- You need to show proof of money you get (income) for the month(s) they got services.

Does anyone applying for benefits have medical bills for services they got in the past 3 months? ☒ Yes ☐ No



Vincent Stolden

if yes, who? (first, middle, last)

Section N

Things Anyone is Paying for or Owns

Skip this section
if you are applying
only for health-care
benefits.

If you need
more room, add
more pages with
the same facts.

Vehicles

Does anyone own or is anyone paying for a:

• car • truck • boat • motorcycle • other ☐ Yes ☐ No

If yes, give facts below.



VEHICLE 1

Name of owner (first, middle, last)

Make/Model

Year

Name of co-owner if also owned by someone outside the home

☐ Vehicle is used for a person with a disability.

\$ Money still owed on vehicle

VEHICLE 2

Name of owner (first, middle, last)

Make/Model

Year

Name of co-owner if also owned by someone outside the home

☐ Vehicle is used for a person with a disability.

\$ Money still owed on vehicle

VEHICLE 3

Name of owner (first, middle, last)

Make/Model

Year

Name of co-owner if also owned by someone outside the home

☐ Vehicle is used for a person with a disability.

\$ Money still owed on vehicle

Social security number:

4 5 9 - 8 1 - 0 5 1 4



Section N

Things Anyone is Paying for or Owns (continued)

Skip this section
if you are applying
only for health-care
benefits.

Things anyone is paying for or owns

We need to know about items anyone owns or is paying for, such as:

- cash • bank accounts • homes and other property • insurance policies • stocks

Does anyone own or is anyone paying for these types of items?..... ☒ Yes ☐ No

If yes, give facts below.

Item 1	Checking accounts	271132272334	\$ 0.00
	Item	Account number	Value
	Names on account or deeds (include co-owners)		
	Money Lion		
Name and address of bank or business (to contact about item)			
Item 2			\$
	Item	Account number	Value
	Names on account or deeds (include co-owners)		
Name and address of bank or business (to contact about item)			
Item 3			\$
	Item	Account number	Value
	Names on account or deeds (include co-owners)		
Name and address of bank or business (to contact about item)			

Section O

Money Coming into the Home

Money anyone might get from other programs

Is anyone waiting for an answer on an application for one of the programs listed below?

☐ Yes ☒ No

If yes, mark the program anyone is waiting to hear from.

- ☐ Social Security (RSDI) ☐ Supplemental Security Income (SSI)
☐ Other disability ☐ Unemployment compensation benefits

Name of person waiting for an answer

Program Name

Social security number:

4 5 9 - 8 1 - 0 5 1 4



Section 0

Money Coming into the Home (continued)

Money from jobs or training

Did anyone get money in the past 3 months from:

(a) working for someone else (b) training, or (c) working for themselves?..... ☒ Yes ☐ No

If yes, give facts below.

Job 1

Vincent Stolden

80

\$ 792.00

before taxes and
deductions are taken out

Name of person who got money from a job

Hours worked

Amount paid

08/21/23

09/2023

Start date

Last payment date (month/year)

How often are you paid?

☐ daily

☐ twice a month

☐ once a week

☐ once a month

☒ every 2 weeks

☐ other: _____

Is this person still working at this job or in training?..... ☐ Yes ☒ No

Was this person working for themselves? ☐ Yes ☒ No

If no, list the person or place that paid the money.

Quest global

Your job may take money out of your check before taxes. These are pretax contributions. They may be for retirement savings, medical insurance premiums, a health savings account, dependent care expenses, commuter expenses or life insurance premiums.

\$ 350.00

Every 2 weeks

09/29/2023

Total pretax contributions per pay period

How often is it contributed

Date contributed

Job 2

Name of person who got money from a job

Hours worked

\$

before taxes and
deductions are taken out

Start date

Last payment date (month/year)

How often are you paid?

☐ daily

☐ twice a month

☐ once a week

☐ once a month

☐ every 2 weeks

☐ other: _____

Is this person still working at this job or in training?..... ☐ Yes ☐ No

Was this person working for themselves? ☐ Yes ☐ No

If no, list the person or place that paid the money.

\$

Total pretax contributions per pay period

How often is it contributed

Date contributed

Social security number:

4 5 9 - 8 1 - 0 5 1 4

Application for benefits
Texas Health and Human Services Commission

H1010
01/2024
Page 13



Section 0

Money Coming into the Home (continued)

Job 3	<input type="text"/>		<input type="text"/>	\$ <input type="text"/>	before taxes and deductions are taken out	
	Name of person who got money from a job		Hours worked	Amount paid		
	<input type="text"/>	<input type="text"/>	How often are you paid? <input type="radio"/> daily <input type="radio"/> twice a month <input type="radio"/> once a week <input type="radio"/> once a month <input type="radio"/> every 2 weeks <input type="radio"/> other: <input type="text"/>			
	Start date	Last payment date (month/year)				
Is this person still working at this job or in training?.....					<input type="radio"/> Yes <input type="radio"/> No	
Was this person working for themselves?					<input type="radio"/> Yes <input type="radio"/> No	
If no, list the person or place that paid the money.					↓	
<input type="text"/>						
\$ <input type="text"/>		<input type="text"/>		<input type="text"/>		
Total pretax contributions per pay period		How often is it contributed		Date contributed		

Social security number:

4	5	9	-	8	1	-	0	5	1	4
---	---	---	---	---	---	---	---	---	---	---



Section 0

Money Coming into the Home (continued)

Other Money

Does anyone get, or expect to get, any of the types of money listed below?..... ☐ Yes ☒ No
If yes mark other types of money anyone gets or might get soon. ↓

- | | | |
|---|--|--|
| <input type="radio"/> Supplemental Security Income (SSI). | <input type="radio"/> Cash or gifts. | <input type="radio"/> Loans paid to anyone on your case. |
| <input type="radio"/> Social Security. | <input type="radio"/> Payments after being hurt at work (worker's compensation). | <input type="radio"/> Payments from private insurance |
| <input type="radio"/> Retirement benefits. | <input type="radio"/> Payments after losing a job (unemployment compensation). | <input type="radio"/> Payments to help with utilities |
| <input type="radio"/> Veterans benefits. | <input type="radio"/> Alimony/Spousal Support | <input type="radio"/> Rent paid to you. |
| <input type="radio"/> Child support anyone gets. | <input type="radio"/> Interest or dividends. | <input type="radio"/> Other _____ |

If anyone gets, or expects to get, any of these types of money, give the facts below.

MONEY TYPE 1

Type of money (item you marked above)

\$

Amount you get paid

Last payment date (month/year)

Name of person getting this money (if child support, list child's name)

Person, company, or agency paying the money

How often are you paid?

- ☐ daily
☐ once a week
☐ every 2 weeks
☐ twice a month
☐ once a month
☐ other: _____

MONEY TYPE 2

Type of money (item you marked above)

\$

Amount you get paid

Last payment date (month/year)

Name of person getting this money (if child support, list child's name)

Person, company, or agency paying the money

How often are you paid?

- ☐ daily
☐ once a week
☐ every 2 weeks
☐ twice a month
☐ once a month
☐ other: _____

MONEY TYPE 3

Type of money (item you marked above)

\$

Amount you get paid

Last payment date (month/year)

Name of person getting this money (if child support, list child's name)

Person, company, or agency paying the money

How often are you paid?

- ☐ daily
☐ once a week
☐ every 2 weeks
☐ twice a month
☐ once a month
☐ other: _____

Social security number:

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Section P

Housing Costs

This section is only for people applying for SNAP food benefits.



Housing costs

1. Does anyone pay any of the costs listed below for the home they are living in?
Or for a home they plan to return to? ☐ Yes ☒ No

If yes, mark the costs they have and list the amount:

<input type="radio"/> Rent or home payment \$ _____	<input type="radio"/> Natural gas/propane \$ _____
<input type="radio"/> Tax on home \$ _____	<input type="radio"/> Phone \$ _____
<input type="radio"/> Water and sewer \$ _____	<input type="radio"/> Home insurance \$ _____
<input type="radio"/> Electricity \$ _____	<input type="radio"/> Other \$ _____

2. Does anyone not on your case and not living in your home help pay your housing costs? ☐ Yes ☒ No

Section Q

Costs to Take Care of Others

Costs to take care of others

Does anyone have costs to take care of others? ☐ Yes ☒ No

If yes, give facts below.

Examples:

- Child care costs so someone can work, look for work, go to training, or go to school.
- Child support payments, medical bills, and health insurance you pay for a child living outside the home.
- Alimony payments.
- Costs for people with disabilities or adults who need help caring for themselves.

COST 1	<input type="text"/>	<input type="text"/>	How often paid? <input type="radio"/> daily <input type="radio"/> once a week <input type="radio"/> every 2 weeks <input type="radio"/> twice a month <input type="radio"/> once a month <input type="radio"/> other: _____
	Type of cost	First name of person who gets care or support	
	<input type="text"/>	<input type="text"/>	
	Who pays the cost?	Amount paid	
	<input type="text"/>		For court ordered child support list child who gets support (provide copy of court order)
Person or company that gets the money (name, address, and phone number)			
COST 2	<input type="text"/>	<input type="text"/>	How often paid? <input type="radio"/> daily <input type="radio"/> once a week <input type="radio"/> every 2 weeks <input type="radio"/> twice a month <input type="radio"/> once a month <input type="radio"/> other: _____
	Type of cost	First name of person who gets care or support	
	<input type="text"/>	<input type="text"/>	
	Who pays the cost?	Amount paid	
	<input type="text"/>		For court ordered child support list child who gets support (provide copy of court order)
Person or company that gets the money (name, address, and phone number)			

Social security number:

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Section R

Medical Costs

This section is only for people applying for SNAP food benefits or health-care benefits.



Medical costs

Does anyone age 60 or older, or anyone with a disability, pay medical costs?..... ☐ Yes ☐ No



If yes, mark the type of costs they pay:

☐ Doctor ☐ Hospital ☐ Medicine ☐ Health insurance

Preferred Method of Contact by Health Plan Providers or Managed Care Organizations

If you get health benefits from us, your health plan provider or managed care organization(MCO) may contact you for the following:

- Appointment reminders
- Information about your health care matters
- Other important notices

You can choose to receive this contact by phone, text message or email.

Text message and e-mail are not encrypted and may not be secure. The risks include an unauthorized third party intercepting confidential or private information. If one of these is your preferred method of communication for your health care, be aware of these risks when sending your personal information by text or email.

Your MCO or health plan provider must take reasonable steps to make sure that your health care information stays private.

By completing the information below, you acknowledge that you understand the risks associated with receiving electronic communications and consent to HHSC sharing your preferred method of contact with your MCO or health plan provider.

Select your preferred contact method from the list below.

Name: Vincent Stolden

Language you prefer to be contacted in : English

2 By telephone

3 By text message

1 By e-mail

Telephone number: (817) 851-4526

(If contacted by cell phone, the call may be auto-dialed or pre-recorded, and your carrier's usage rates may apply.)

Cell phone number: (817) 851-4526

(Carrier message and data rates may apply)

E-mail address: krazyv3@gmail.com

Social security number:

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Section S

People Helping You

People helping you

Did someone help you fill out this form? ☐ Yes ☒ No



If yes, tell us about that person:

Name

Relationship or organization

Phone

Address

Section T

Signing Up to Vote (optional)

Signing up to vote

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 are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☒ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, PO Box 12060, Austin, TX 78711. Phone: 1-800-252-8683

Agency Use Only: Voter Registration Status

- ☐ Already registered ☐ Client declined ☐ Agency transmitted
☐ Client to mail ☐ Mailed to client ☐ Other

Agency staff signature

Social security number:

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Section U

A Person Who Can Act for You



Don't forget
to sign the
last page.

Person who has the right to act for you

If you want, you can give someone the right to act for you (an authorized representative).

That person can:

- Give and get facts for this application
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed to enroll in health-care benefits. This includes picking a health plan.
- Take any action needed to get benefits. This includes reporting changes and renewing benefits.

If you give someone the right to act for you, that person agrees to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
 - laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
 - laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
 - laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

Do you want to give someone the right to act for you - to be your authorized representative?

☐ Yes ☒ No

If yes, tell us about that person (the authorized representative):



Name of person who you want to have the right to act for you.

Address

Phone

Social security number:

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Section V

Legal Information

Legal information

Your Right to be Treated Fairly

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.

Supplemental Nutrition Assistance Program (SNAP)

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

(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/snap/contact_info/hotlines.htm

Medicaid and Temporary Assistance for Needy Families

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 509F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY). This institution is an equal opportunity provider. You also can file a complaint with the Texas Health and Human Services Commission, Civil Rights Office. Email HHSCivilRightsOffice@hhsc.state.tx.us, call 1-888-388-6332, fax (512) 438-5885, or write Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751.

This institution is an equal opportunity provider.

You also can file a complaint with the Texas Health and Human Services Commission, Civil Rights Office. Email HHSCivilRightsOffice@hhsc.state.tx.us, call 1-888-388-6332, fax (512) 438-5885, or write Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751.

Citizenship and Immigration Status

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps immigrants with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

Social Security Numbers

You only need to give the Social Security numbers (SSNs) for people who want benefits. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN can't get benefits. If you don't have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have an SSN and you don't. We will not give SSNs to the Bureau of Immigration and Customs Enforcement. We will use SSNs to check the amount of money you get (income), if you can get benefits, and the amount of benefits you can get. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at <https://veterans.portal.texas.gov>.

Social security number:

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Section W

Statement of Understanding

Read Section W before signing the last page.

All Benefit Programs Facts HHSC Has About Me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping My Facts Private

HHSC will keep my facts private if they were collected:

- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

HHSC can share facts about me:

- When needed for me to get state health-care benefits.
- With phone and utility companies. They will find out if my bill amount can be lowered. HHSC will give them my name, address, and phone number.

TANF Cash Help for Families Child Support or Alimony



I agree to:

- Let the state keep any child support or alimony money owed to anyone during the time they get TANF.
- Let the state keep this money after TANF benefits end, if the TANF amount anyone got still needs to be paid off.
- Tell HHSC about money anyone gets.
- Work with HHSC to get this money; if I don't, I am breaking the law.

The state will keep only the amount allowed by law.

If I Give False Information

If I choose not to tell the truth, I might:

- Be charged with and punished for a crime. (This could include going to prison for up to 10 years or community supervision.)
- Have to repay benefits.
- Never get TANF again.

SNAP Food Benefits Telling the Truth



Anyone who applies for or gets SNAP must:

- Tell the truth.
- Never trade or sell SNAP benefits, Lone Star Cards, or other devices that allow people to get SNAP.

Anyone who chooses not to tell the truth might:

- Not get SNAP for a year or more.
- Be fined up to \$250,000, jailed up to 20 years, or both.
- Lose income tax refunds.
- Be charged with other crimes.
- Have to repay benefits.
- Never get SNAP again.

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will be not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to participate in the program upon the first occasion of such violation.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of \$500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.

An individual found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the program for a period of 10 years.

The same is true if anyone lets someone else use their Lone Star Card.

Facts Anyone Tells or Gives HHSC

HHSC uses the facts anyone tells or gives HHSC, including Social Security numbers to:

- Check if that person can get benefits.
- Check that person's facts with computer matching programs and credit report agencies.
- Make sure that person is following benefit program rules.
- Help other agencies check if that person can get other benefits.
- Recover benefits that person wasn't supposed to get.
- Share facts about that person: (1) with other state and federal agencies (for example, the Texas Workforce Commission, the Social Security Administration, and the Internal Revenue Service); (2) with law enforcement officials so they can find people on that person's benefits case (the household) who are wanted for fleeing the law; and (3) with federal, state, and private claims collecting agencies for food benefit overpayment claims collection action.

(Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.)

More on next page



Social security number:

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Section W

Statement of Understanding



Did you...

1. Sign and date page 1 (if you have not already sent it in).
2. Include the "items we need" listed in the cover section.
3. Sign and date this page.



Medicaid

If I Give False Information

If I choose not to tell the truth, I might:

- Be charged with a crime.
- Have to repay benefits.

The same is true if I let someone else use my medical card or Medicaid ID.

Giving Out Facts About Me

I agree to let Medicaid health care providers (doctors, drug stores, hospitals, etc.) give out any facts about me to HHSC. This will allow the providers to be paid by Medicaid.

Medical and Child Support Payments

Depending on my benefits case, the Attorney General (the state) might check that I am getting the right amount of child or medical support payments and coverage.

- If only my child gets Medicaid, I can decide if I want the state to help get any payments and coverage we should get, but don't get right now.
- If my child and I both get Medicaid, I must:
 - Help the state get any payments and coverage we should get, but don't right now.

If I don't help the state, my child can get Medicaid, but I might not.

- Identify who the child's other parent is.
- Allow the state to keep any medical support payments.

- I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell HHSC and I may not have to cooperate.

If I get Medicaid, HHSC will keep medical service payments I can get from other sources, such as:

- My health insurance.
- Money I got because of injuries.
- Money collected for me or my children by the Office of Attorney General.

I must tell HHSC about these sources. If I don't, I am breaking the law.

HHSC will only keep the amount of medical support and service payments allowed by law. I will work with HHSC to get these funds.

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
- To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
- The facts to be checked and shared include anything that helps decide: 1) who can get benefits, and (2) the amount of benefits.

My Answers Are True

Sign here to show you agree:

I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

Person applying or their authorized representative:

Signed online: Vincent Stolden

Sign here

1 1 / 0 8 / 2 0 2 3

Date

Parent, guardian, or power of attorney for the person applying:

Sign here (you must give proof of this right)

Phone

Sign here

Date

Witness (only needed if anyone above signed with an "X" or other mark):

Sign here

Sign here

Date

Printed name of witness

Social security number:

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Addendum

Contact information

Vincent Stolden	
Home address	
Home address (line 1):	2401 Colt Ln
City:	Crowley
State:	Texas
ZIP:	76036
County:	Tarrant
Mailing address	
Mail address (line 1):	2401 Colt Ln
City:	Crowley
State:	Texas
ZIP:	76036
County:	Tarrant
Language for letters and forms	
Language for letters and forms we send you:	English

Benefits for this person

Vincent Stolden	
Benefit:	SNAP food benefits
Benefit:	Adult who isn't taking care of a child

School

Addendum

Vincent Stolden

Date this person plans to graduate:

Tax return status

Vincent Stolden

Do you plan to file a federal income tax return next year? **Yes**

Will you file taxes with a spouse? **No**

Facts about the people you will claim

Will you claim any dependents on your tax return? **No**

How is this person related to you?

Facts about the people who will claim you

Will someone claim you on their tax return? **No**

How is this person related to you?

Other health insurance

Vincent Stolden

Reason why health coverage ended:

Is the money you get (income) or things you are paying for or own (resources) different today than it was in the past 3 months? **No**

Cash, loans, accounts

Facts about the cash, loan, or account

Type of cash, loan, or account: **Checking accounts**

Person who owns or has the cash, loan, or account: **Vincent Stolden**

Addendum

Account number: **271132272334**

Value: **\$0.00**

Name of bank, business, or person to contact about this cash,
loan, or account: **Money Lion**

Money you expect to get

Vincent Stolden

Total amount of money this person expects to get this year: **\$0.00**

Total amount of money this person expects to get next year: **\$0.00**

Has this person ever gotten health-care services or a referral from
either: (1) the Indian Health Service, (2) a tribal health program,
or (3) an urban Indian health program? **No**

Is this person able to get health-care services or a referral from
either: (1) the Indian Health Service, (2) a tribal health program,
or (3) an urban Indian health program? **No**

Other questions (Agency use only)

Have you been helped by an assister organization? **No**

Did this person ask to apply for health-care benefits for an adult
who isn't taking care of a child? **Yes**

Do you agree to allow the agency to renew your health coverage
in future years? **No - I don't agree**

Individual Information (Agency use only)

Vincent Stolden

Social security number: **459-81-0514**

Does this person have any costs for things such as: educator
expenses, health savings accounts, or moving? **No**

Does this person have any costs for education or school? **No**

Addendum

Did this person ask to apply for health-care benefits for an adult who isn't taking care of a child? **Yes**

Did this person ask to apply for health-care benefits for people who were in foster care? **No**

Foster care

Was client in Foster care? **No**

Employment (Agency use only)

Vincent Stolden

Employer

Employer name: **Quest global**

Employer identification number: **0**

Employer phone number: **0**

Employer insurance

Is this a state health benefit plan? **No**

Does the employer offer a health plan that meets the minimum value standard? **Yes**

Employer lowest cost plan cost: **\$450.00**

Employer lowest cost plan payment frequency: **Bi-Weekly**

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? **Yes**

Person eligible to enroll date: **08/24/2023**

Will this employer stop offering insurance coverage next year? **No**

Amount this person would need to pay each month for the new insurance premium: **\$0.00**

What can I buy with SNAP?

SNAP food benefits are used to buy food and garden seeds. Most grocery stores accept SNAP.

You **can't** use SNAP to:

- Buy tobacco.
- Buy alcoholic drinks.
- Buy things you can't eat or drink.
- Pay for food bills you already owe.

How will I get my SNAP benefits?

You will get a plastic card called the Lone Star Card. Every month your SNAP amount will be put in your Lone Star Card account. You will use this card like a credit card at the cash register. To get help with your card, call 1-800-777-7328 (toll-free).

Can I get SNAP?

You might be able to get SNAP if the money you get (income) and the things you own are under a set limit.

Some things you own are not counted, for example:

- Your home
- Personal items
- Life insurance policies

How will I know how much I have in my SNAP account?

We will send you a letter telling you how much you will get each month. You can check your balance by logging into your account at YourTexasBenefits.com or by calling the Lone Star Card help line at 1-800-777-7328 (toll-free).

How long will I get SNAP?

We will send you a letter telling you how long your benefit period is. Most adults age 18 to 49 who do not have a child in the home can get SNAP benefits for only 3 months in a 3-year period. The benefit period can be longer if the adult works at least 20 hours a week or is in an approved work program. Some might not have to work or be in a work program to get benefits, such as those who have a disability or are pregnant.

How do I apply?

- **Online:** YourTexasBenefits.com.
- **At a benefits office:** To find a Texas Health and Human Services Commission (HHSC) benefits office near you, go to YourTexasBenefits.com or call 2-1-1 (after you pick a language, press 1).
- **Paper form (H1010):** To get a form, you can either:
 - Call 2-1-1 (after you pick a language, press 2);
 - Call toll-free 1-877-541-7905 (after you pick a language, press 2); or
 - Visit an HHSC benefits office.

Can someone else buy food for me?

You can get a Lone Star Card for another person. That person can use the card to buy food for you. You are responsible for what that person buys with that card. If a card is lost or stolen, you must call us right away at 1-800-777-7328 (toll-free). We will not replace any SNAP benefits used before you report the loss or theft of the card.

Your Rights

1. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating 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, audiotope, 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 mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

This institution is an equal opportunity provider.

You also can write to Texas Health and Human Services, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751, or call 1-888-388-6332.

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.

2. You can give us your application form in person or by mail. Another person can give us the form for you. You don't have to go to an interview before giving us your form. You can give us the form the same day you get it. We must accept your form if we can read your name and address, and it has been signed.
If you need help filling out the form or applying, we will help you.
3. You can request a paper or electronic copy of any application you filled out and gave to us, regardless of the original method of submission by calling 211, visiting your local office, or logging in to your YourTexasBenefits.com account.
4. We must give you benefits within 30 days after you give us your application if you: (a) give us everything on time, and (b) we find you meet SNAP program limits. Some people with very little money might get benefits the next workday after they apply.
5. You can talk to the office supervisor if: (a) you have questions that your caseworker can't answer, or (b) you disagree with a decision your caseworker makes.
6. You can file a complaint by calling 2-1-1. If you don't get the help you need there, you can call the HHSC Office of the Ombudsman at 1-877-787-8999. Both numbers are free to call.
7. If you think any action taken on your case is wrong, you can ask for a hearing to appeal. A hearing is a chance for you to tell a hearing officer the reasons you think the action is wrong. The hearing officer will decide if the right action was taken.
8. A child who gets SNAP will get free school lunches. The child must: (a) go to a public or private school, and (b) be in grades pre-school to high school. Contact your child's school if:
 - You don't want your child to get free school lunches.
 - You think your child should get free school lunches but doesn't.
 - You have questions about the free school lunch program.

Program Rules

1. Anyone who applies for or gets SNAP must tell the truth about their benefits case.
2. It is against the law for anyone to do or try to do any of the following:
 - Trade, sell, or steal SNAP benefits or Lone Star Cards.
 - Share their Lone Star Card PIN (password).
 - Use Lone Star Cards that don't belong to them.
 - Sell food they make with items bought with SNAP benefits.
 - Buy items in refundable containers with SNAP benefits to get refunds and not use the items.
 - Re-sell items bought with SNAP benefits.
3. Most people age 16 to 59 must follow work rules to get SNAP benefits. Work rules mean a person must look for a job or be in an approved work program. If the person has a job, they can't quit without good cause. A person who doesn't follow the work rules will be penalized.

If your SNAP case has more than one parent or caretaker with a child (age 17 or younger), you must decide which parent or caretaker will be listed as the "primary wage earner." If you don't decide who will be the primary wage earner, HHSC will decide for you. If the primary wage earner doesn't follow the work rules, **everyone** on the SNAP case will be penalized. Penalties:

- **1st time:** No SNAP benefits for 1 month or longer (until the person follows the rules).
 - **2nd time:** No SNAP benefits for 3 months or longer (until the person follows the rules).
 - **3rd time:** No SNAP benefits for 6 months or longer (until the person follows the rules).
4. You must tell us about changes to your case within 10 days of the change. We gave you a list that shows the changes we need to know about (see Form H1019, Report of Change).
 5. If you get more SNAP benefits than you should, you must pay them back.
 6. If you move out of the state before using all the benefits in your account, you can use your Lone Star Card at stores that accept SNAP benefits in other states.
 7. These are the penalties for people who break SNAP rules on purpose:
 - **1st time:** Can't get SNAP for 1 year.
 - **2nd time:** Can't get SNAP for 2 years.
 - **3rd time:** Can never get SNAP again.If a court of law decides you can't get benefits, the court will decide for how long.
 8. If you have a felony drug conviction on or after September 1, 2015 and:
 - If you don't follow parole or community supervision rules, you might not get SNAP for 2 years.
 - If you get another felony drug conviction while you are getting SNAP, you can't ever get SNAP again.

If you have any questions, call 2-1-1.

¿Qué puedo comprar con el Programa SNAP?

Los beneficios de comida del Programa SNAP se usan para comprar alimentos y semillas para huertos. Casi todos los supermercados aceptan el Programa SNAP.

Usted **no puede** usar el Programa SNAP para:

- Comprar tabaco.
- Comprar bebidas alcohólicas.
- Comprar cosas que no se puedan comer ni beber.
- Pagar cuentas de alimentos que ya debe.

¿Cómo recibo los beneficios del Programa SNAP?

Recibirá una tarjeta de plástico llamada tarjeta Lone Star. Cada mes la cantidad asignada por el programa SNAP se cargará a su tarjeta Lone Star. Usted usará su tarjeta en la caja como una tarjeta de crédito. Para recibir ayuda con la tarjeta, llame al 1-800-777-7328 (sin costo).

¿Puedo recibir beneficios del Programa SNAP?

Usted podría recibir beneficios del Programa SNAP si el dinero que recibe (sus ingresos) y sus propiedades están por debajo de un límite fijo.

Algunas de sus propiedades no se toman en cuenta, como por ejemplo:

- Su casa
- Artículos personales
- Pólizas de seguro de vida

¿Cómo sé cuánto tengo en la cuenta del Programa SNAP?

Le enviaremos una carta diciéndole cuánto recibirá cada mes. Puede revisar el saldo ingresando a su cuenta en YourTexasBenefits.com o llamando a la línea de ayuda de la tarjeta Lone Star al 1-800-777-7328 (sin costo).

¿Por cuánto tiempo recibiré beneficios de comida del Programa SNAP?

Le enviaremos una carta diciéndole por cuánto tiempo puede cobrar beneficios. La mayoría de los adultos entre 18 y 49 años, sin hijos en la casa, puede recibir beneficios del Programa SNAP por solo 3 meses en un periodo de 3 años. El periodo de beneficios puede ser más largo si el adulto trabaja por lo menos 20 horas por semana o si está en un programa aprobado de trabajo. Puede ser que algunos no tengan que trabajar ni estar en un programa de trabajo para recibir beneficios, como las personas discapacitadas o las mujeres embarazadas.

¿Cómo solicito estos beneficios?

- **En línea:** YourTexasBenefits.com
- **En una oficina de beneficios:** Para encontrar una oficina de beneficios de la Comisión de Salud y Servicios Humanos (HHSC) cerca de usted, vaya a YourTexasBenefits.com o llame al 2-1-1 (después de seleccionar un idioma, oprima el 1).
- **Con una forma en papel (H1010):** Para recibir una forma, tiene dos opciones:
 - Llame al 2-1-1 (después de seleccionar un idioma, oprima el 2);
 - Llame sin costo al 1-877-541-7905 (después de seleccionar un idioma, oprima el 2); o
 - Visite una oficina de beneficios de la HHSC.

¿Puede otra persona comprarme los alimentos?

Usted puede obtener una tarjeta Lone Star para otra persona. Esa persona puede usar la tarjeta para comprarle los alimentos a usted. Usted es responsable de lo que esa persona compre con esa tarjeta. Si se pierde o le roban la tarjeta, usted tiene que llamarnos inmediatamente al 1-800-777-7328 (gratis). No le reembolsaremos por ningún beneficio del Programa SNAP usado antes de avisar sobre la pérdida o el robo de la tarjeta.

Sus derechos

1. De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, credo religioso, discapacidad, edad, creencias políticas, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o con discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] llamando al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en línea en: http://www.ocio.usda.gov/sites/default/files/docs/2012/Spanish_Form_508_Compliant_6_8_12_0.pdf, y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por correo a U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, por fax (202) 690-7442, o correo electrónico a program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

También puede comunicarse con la Oficina de Derechos Civiles de la HHS de Texas. Escriba a Salud y Servicios Humanos de Texas, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751, o llame al 1-888-388-6332.

Para obtener información adicional relacionada con problemas con el Programa de Asistencia Nutricional Suplementaria (SNAP, por sus siglas en inglés), las personas deben comunicarse con el número de línea directa de USDA SNAP Hotline al (800) 221-5689, que también está disponible en español, o llame a los números de [información/líneas directas de los estados](http://www.fns.usda.gov/snap/contact_info/hotlines.htm) (haga clic en el vínculo para ver una lista de los números de las líneas directas de cada estado) que se encuentran en línea en: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

2. Nos puede dar la solicitud en persona o la puede enviar por correo. Otra persona nos la puede entregar a nombre suyo. Usted no tiene que ir a una entrevista antes de entregarnos la solicitud. Nos la puede dar el mismo día que la recibe. Tenemos que aceptar la solicitud si su nombre y dirección se pueden leer, y si está firmada. Si necesita ayuda para llenar la solicitud, podemos ayudarlo.
3. Puede solicitar una copia impresa o electrónica de cualquier solicitud que haya completado y nos haya entregado, independientemente del método original de envío, llamando al 211, visitando su oficina local o ingresando a su cuenta YourTexasBenefits.com.
4. Tenemos que darle los beneficios dentro de 30 días después de recibir su solicitud, si usted: (a) nos da todo a tiempo y (b) decidimos que usted satisface los límites del Programa SNAP.
Algunas personas con muy poco dinero podrían recibir beneficios el siguiente día laboral después de presentar la solicitud.
5. Puede hablar con el supervisor de la oficina si: (a) tiene preguntas que el trabajador de casos no puede contestar o (b) no está de acuerdo con una decisión del trabajador de casos.
6. Puede presentar una queja llamando al 211. Si no le dan la ayuda que necesita, también puede llamar a la Oficina del Ombudsman de la HHSC al 1-877-787-8999. Llamar a estos teléfonos es gratis.
7. Si cree que alguna acción tomada en su caso es incorrecta, puede pedir una audiencia para apelarla. Una audiencia es una oportunidad para decirle al funcionario de audiencias las razones por las cuales cree que la acción es incorrecta. El funcionario de audiencias decidirá si se tomó la acción correcta.
8. Un niño que recibe beneficios del Programa SNAP recibirá el almuerzo gratis en la escuela. El niño tiene que: (a) asistir a una escuela pública o privada y (b) estar en cualquier grado desde el prekindergarten hasta la preparatoria.
Comuníquese con la escuela de su hijo si:
 - No quiere que su hijo reciba el almuerzo gratis en la escuela.
 - Cree que su hijo debe recibir el almuerzo gratis, pero no lo recibe.
 - Tiene preguntas sobre el programa de almuerzo gratis.

Reglas del programa

1. Cualquier persona que solicite o reciba beneficios del SNAP tiene que decir la verdad sobre su caso de beneficios.
2. Es contra la ley que cualquier persona haga o trate de hacer una de las siguientes:
 - Intercambiar, vender o robar beneficios del SNAP o de las tarjetas Lone Star.
 - Compartir su número de PIN (contraseña) de la tarjeta Lone Star.
 - Usar tarjetas Lone Star que no le pertenecen.
 - Vender comida que preparen con artículos comprados con los beneficios del SNAP.
 - Comprar artículos en recipientes reembolsables con los beneficios del SNAP para recibir reembolsos y no usar los artículos.
 - Revender artículos que compró con los beneficios de comida del SNAP.

3. La mayoría de las personas entre 16 y 59 años tiene que seguir las reglas de empleo para recibir beneficios del Programa SNAP. Según las reglas de empleo, una persona tiene que buscar trabajo o estar en un programa aprobado de trabajo. Si la persona tiene trabajo, no puede dejarlo sin tener un motivo justificado. La persona que no sigue las reglas de empleo será sancionada.

Si en su caso del Programa SNAP hay más de un padre o cuidador con un niño (de 17 años o menos), usted tiene que decidir cuál padre o cuidador aparecerá como el "principal sostén económico." Si no decide quién va a ser el principal sostén económico, la HHSC decidirá por usted. Si el principal sostén económico no sigue las reglas de empleo, todas las personas que estén en el caso del Programa SNAP serán sancionadas. Sanciones:

- **1.a vez:** No recibirá beneficios del Programa SNAP por 1 mes o por más tiempo (hasta que la persona siga las reglas).
 - **2.a vez:** No recibirá beneficios del Programa SNAP por 3 meses o por más tiempo (hasta que la persona siga las reglas).
 - **3.a vez:** No recibirá beneficios del Programa SNAP por 6 meses o por más tiempo (hasta que la persona siga las reglas).
4. Usted tiene que decirnos sobre cambios en su caso dentro de 10 días después del cambio. Le dimos una lista que muestra los cambios que necesitamos saber (vea la Forma H1019s, Informe de cambio).
 5. Si recibe más beneficios del Programa SNAP de los que debería recibir, tiene que devolver el exceso.
 6. Si se muda fuera del estado antes de usar todos los beneficios en su cuenta, puede usar la tarjeta Lone Star en otros estados en los supermercados que acepten beneficios del Programa SNAP.
 7. Estas son las sanciones que sufrirán las personas que intencionalmente violan las reglas del Programa SNAP:
 - **1.a vez:** No puede recibir beneficios del Programa SNAP por 1 año.
 - **2.a vez:** No puede recibir beneficios del Programa SNAP por 2 años.
 - **3.a vez:** Jamás volverá a recibir beneficios del Programa SNAP.
- Si una corte decide que usted no puede recibir beneficios, la corte decidirá por cuánto tiempo.
8. Si usted ha sido declarado culpable de un delito grave relacionado con drogas del 1^o de septiembre de 2015 en adelante, y:
 - Si usted no cumple con las reglas de su libertad condicional o supervisión comunitaria, no podrá recibir beneficios de SNAP por 2 años.
 - Si es declarado culpable de otro delito grave relacionado con drogas mientras recibe beneficios de SNAP, no podrá jamás volver a recibir beneficios de SNAP.

Si tiene alguna pregunta, llame al 211.

Billing for Vincent Ardran Stolden Jr.

Hospital Services for Guarantor #510153406
View Acclaim Physician Services

JPS Health Network
View Acclaim Physician
Services

Save time with MyChart

Sign up for MyChart to access your personal healthcare information with your computer or smartphone.

Create account

Visit Accounts

Currently viewing: Active accounts ^

Active accounts

Year to date

Last year

Date range

Outstanding Balance

Admission at Jps Trinity Springs

Sep 18, 2023 to Sep 23, 2023

Sep
18
2023

Hospital Services

Provider: Farooq, Malik

Patient: Vincent Ardran Stolden Jr.

Primary Payer: United Healthcare

Account #60014452818

Billed \$13,239.00

Insurance Covered -\$12,739.00

You Paid \$0.00

Your Balance \$500.00

Detailed Account Information

Behavioral Health Treatments \$2,186.00

Psychosocial Evaluation - 90791 (CPT®) \$1,019.00

Psychotherapy Group - 90853 (CPT®) \$389.00

Psychotherapy Group - 90853 (CPT®) \$389.00

Psychotherapy Group - 90853 (CPT®) \$389.00

Emergency Room \$942.00

Emergency Visit Level III Pec - 99283 (CPT®) \$942.00

Laboratory \$807.00

Venipuncture - 36415 (CPT®) \$37.00

Cbc Platelet Auto 5 Diff - 85025 (CPT®) \$154.00

Comp Metabolic Profile - 80053 (CPT®) \$257.00

TSH - 84443 (CPT®) \$113.00

Lipid Profile - 80061 (CPT®) \$99.00

Glycohemoglob Re3 - 83036 (CPT®) \$69.00

Free T4 Rk4 - 84439 (CPT®) \$78.00

Pharmacy \$16.00

Aripiprazole 5 Mg Tab (50268-088-11) \$4.00

Aripiprazole 5 Mg Tab (50268-088-11) \$4.00

Aripiprazole 5 Mg Tab (50268-088-11) \$4.00

Aripiprazole 5 Mg Tab (50268-088-11) \$4.00

Room and Board - Semi Private \$9,288.00

Semi Private Room Tsp \$2,322.00

Semi Private Room Tsp \$2,322.00

Semi Private Room Tsp \$2,322.00

Semi Private Room Tsp \$2,322.00

Payments and Adjustments

Cigna -\$2,700.00

United Healthcare -\$10,039.00

Your total balance for outstanding visit accounts: **\$500.00**



SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR



Type / Type / Tipo Code / Code / Código Passport / No. du Passeport / No. de Pasaporte
506012568

P USA 506013568

Surname / Nom / Apellidos

STOLDEN JR

Given Names / Prénoms / Nombres

VINCENT ARDRAN

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
(País de nacimiento)

UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento

14 Jan 1987

14 Jan 1987
Place of birth / Lieu de naissance / Lugar de nacimiento

TEXAS, U.S.A.

TEXAS, U.S.A.
Date of issue / Date de délivrance / Fecha de expedición

25 Apr 2016

25 Apr 2016
Date of expiration / Date d'expiration / Fecha de caducidad

24 Apr 2026

24 Apr 2026
Endorsements / Mentions Spéciales / Anotaciones

SEE PAGE 51

Sex / Sexe / Sexo

M

Authority / Autorité / Autorität

United States

Department of State

USA

P<USASTOLDEN<JR<<VINCENT<ARDRAN<<<<<<<<<<<<

P<USASTOLDEN<JR<<VINCENT<ARDRAH
5060135688USA8701141M2604240550799671<205978





PO Box 3475
Toledo, Ohio 43607-0475

Acclaim Customer Service: 817-702-8450

LAST PMT:
AMOUNT :

Check box if address/insurance is incorrect,
update on reverse side

FILL OUT CREDIT CARD INFORMATION BELOW:		
CHECK CARD USING FOR PAYMENT		
		
CARD NUMBER		SIGNATURE CODE
SIGNATURE		EXP DATE
STATEMENT DATE 10/28/23	PAY THIS AMOUNT 85.23	ACCT. # 510153406
AMOUNT PAID \$		

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

Charges				
Date	Description	Charges	Credits	Balance
Visit on 9/20/2023 with ONG, DARRYL - Patient STOLDEN,VINCENT ARDRAN JR.				
09/20/2023	1st Hospital IP/Obs Care High Mdm 75 Minutes	345.48		39.29
10/03/2023	Insurance Payment - Cigna		117.86	
10/27/2023	Insurance Payment - United Healthcare		0.00	
10/03/2023	Insurance Adjustment - Cigna		188.33	
Visit on 9/21/2023 with OYEKA, MICHELLE CHINENYE - Patient STOLDEN,VINCENT ARDRAN JR.				
09/21/2023	Sbsq Hospital IP/Obs Care High Mdm 50 Minutes	237.02		28.25
10/03/2023	Insurance Payment - Cigna		84.75	
10/27/2023	Insurance Payment - United Healthcare		0.00	
10/03/2023	Insurance Adjustment - Cigna		124.02	
Visit on 9/23/2023 with ASSEFAW, AARON ROBELL - Patient STOLDEN,VINCENT ARDRAN JR.				
09/23/2023	Hospital IP/Obs Discharge Day Mgmt 30 Min/<	161.02		17.69
10/03/2023	Insurance Payment - Cigna		53.07	
10/27/2023	Insurance Payment - United Healthcare		0.00	
10/03/2023	Insurance Adjustment - Cigna		90.26	

PAY THIS AMOUNT

85.23

Message

Pay By Mail

Complete the form above and return in the enclosed envelope.

Make checks payable to Acclaim Physician Group

Pay By Phone or Billing Questions

Call (817) 702-8450
8:00am to 4:00pm Monday through Friday

Pay Your Bill Online



To conveniently make payments, schedule appointments, view test results, and more!

<https://jpsmychart.jpshealth.org>

Activation Code:

Need an activation code? Please contact customer service

Just want to pay your bill and not activate mychart? Go to

<https://jpsmychart.jpshealth.org/jpsmychart/billing/guestpay/>

STOLDEN, VINCENT A

B M 1/14/1987

Tarrant County Inmate



CID: 1021229

CO. FILE DEPT. CLOCK VCHR. NO. 010
EG3 162940 OBU-NA 0000391208 1

Earnings Statement



QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

Period Beginning: 09/11/2023
Period Ending: 09/24/2023
Pay Date: 09/29/2023

Filing Status: Head of household
Exemptions/Allowances:
Federal: Standard Withholding Table

VINCENT STOLDEN
2401 COLT LANE
CROWLEY TX 76036

				year to date
Regular	26.0000	32.00	832.00	3,640.00
Lve-Encash	26.0000	9.33	242.58	242.58
Empl Vacation				104.00
Holiday				208.00
				4,194.58

Other Benefits and Information

	this period	total to date
Group Term Life	2.08	6.24
Totl Hrs Worked	32.00	

COMPANY PHONE IS : (860) 290-1145

BASIS OF PAY: HOURLY

Federal Income Tax	-15.41	154.44
Social Security Tax	-59.29	238.05
Medicare Tax	-13.86	55.67

Other

Critical Illnes	-2.45	7.35
Dental Insuranc	-16.64*	49.92
Hosp Ins Post	-11.31	
Legal	-11.08	33.24
Medical	-97.18*	291.54
Vision Benefits	-6.62*	19.86
Whole Life	-48.74	97.48

CHECKING A/C -792.00

Exemptions/Allowances:

TX: No State Income Tax

* Excluded from federal taxable wages

Your federal taxable wages this period are \$954.14

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QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

Advice number: 00000391208
Pay date: 09/29/2023

Deposited to the account of	account number	transit ABA	amount
VINCENT STOLDEN	xxxxxxx2334	xxxx xxxx	\$792.00

NON-NEGOTIABLE

Earnings Statement



QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

Period Beginning: 08/14/2023
Period Ending: 08/27/2023
Pay Date: 09/01/2023

Filing Status: Head of household
Exemptions/Allowances:
Federal: Standard Withholding Table

VINCENT STOLDEN
2401 COLT LANE
CROWLEY TX 76036

Earnings	rate	hours	this period	year to date
Regular	26.0000	40.00	1,040.00	1,040.00
Gross Pay			\$1,040.00	1,040.00

Other Benefits and Information	this period	total to date
Group Term Life	2.08	2.08
Totl Hrs Worked	40.00	

Deductions	Statutory	
Federal Income Tax	-11.96	11.96
Social Security Tax	-57.14	57.14
Medicare Tax	-13.36	13.36

Deposits	
Account No.	xxxxxxxx2334
Transit/ABA	xxxx xxxx
Pending	

Other	
Critical Illnes	-2.45
Dental Insuranc	-16.64*
Hosp Ins Post	-11.31
Legal	-11.08
Medical	-97.18*
Vision Benefits	-6.62*

Important Notes
COMPANY PHONE IS : (860) 290-1145

Net Pay \$812.26

BASIS OF PAY: HOURLY

YOUR BANK WAS NOTIFIED OF YOUR REQUEST FOR DIRECT DEPOSIT. IT WILL BEGIN AFTER ACCOUNT VERIFICATION.

Net Check \$812.26

Additional Tax Withholding Information
Exemptions/Allowances:
TX: No State Income Tax

* Excluded from federal taxable wages
Your federal taxable wages this period are \$919.56

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QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

EG3 90-477/1222
Payroll check number: 0020082692
Pay date: 09/01/2023

Pay to the order of: VINCENT STOLDEN

This amount:	EIGHT HUNDRED TWELVE AND 26/100 DOLLARS	\$812.26
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ASSISTANCE WITH VERIFICATION AVAILABLE AT 877-423-7243
VOID AFTER 180 DAYS
VOID NON-NEGOTIABLE

Wells Fargo Bank, N.A.
111 Congress Ave
Austin, TX 78701

THIS IS NOT A CHECK

CO. FILE DEPT. CLOCK VCHR. NO. 010
EG3 162940 OBU-NA 0000371215 1

Earnings Statement



QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

Period Beginning: 08/28/2023
Period Ending: 09/10/2023
Pay Date: 09/15/2023

Filing Status: Head of household
Exemptions/Allowances:
Federal: Standard Withholding Table

VINCENT STOLDEN
2401 COLT LANE
CROWLEY TX 76036

				year to date
Regular	26.0000	68.00	1,768.00	2,808.00
Empl Vacation	26.0000	4.00	104.00	104.00
Holiday	26.0000	8.00	208.00	208.00
				3,120.00

Other Benefits and Information

	this period	total to date
Group Term Life	2.08	4.16
Totl Hrs Worked	68.00	

COMPANY PHONE IS : (860) 290-1145

BASIS OF PAY: HOURLY

Federal Income Tax	-127.07	139.03
Social Security Tax	-121.62	178.76
Medicare Tax	-28.45	41.81

Other

Critical Illnes	-2.45	4.90
Dental Insuranc	-16.64*	33.28
Hosp Ins Post	-11.31	
Legal	-11.08	22.16
Medical	-97.18*	194.36
Vision Benefits	-6.62*	13.24
Whole Life	-48.74	48.74

Exemptions/Allowances:

TX: No State Income Tax

CHECKING A/C -1,608.84

* Excluded from federal taxable wages

Your federal taxable wages this period are
\$1,959.56

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QUEST GLOBAL SERVICES
175 ADDISON ROAD
SUITE F
WINDSOR, CT 06095

Advice number: 00000371215
Pay date: 09/15/2023

Deposited to the account of	account number	transit ABA	amount
VINCENT STOLDEN	xxxxxxx2334	xxxx xxxx	\$1,608.84

NON-NEGOTIABLE