HINDS COUNTY DHS-MAIN OFF.
4777 MEDGER EVERS BLVD
JACKSON , MS 39213

State Of Mississippi
Department Of Human Services

ROBERTA S BURKS
3933 ILANO DRIVE
JACKSON , MS 39212

COUNTY : 250
TELEPHONE : (601)362-9892
Case Number: 162874659
WORKER : BARBARA FOSTER

DATE : 11/28/2023

Form: F101 SNAP APPROVAL NOTICE F101
Your application received November 8, 2023 has been approved.

Your household is certified from DEC 2023 through May 2024 :
You are authorized to receive:
$701 for December 2023 through MAY 2024
$ for through
$ for through

__ If this block is checked, your first month's benefit will be available immediately. Future benefits will be available on your regular availability date.

__ If this block is checked, your benefits were approved without allowing a deduction for . If you provide verification, future benefits could change.

__ If this block is checked, your SNAP benefits are being sanctioned because .

__ If this block is checked, your SNAP benefits will be reduced by $ each month to recover the amount of your SNAP overpayment.

Your benefits are based upon a household size of 3 , gross earned income of $150.00 , and gross unearned income of $292.49 .

If you do not already have an Electronic Benefit Transfer card, you will receive one in the mail along with instructions for activation. Any benefit representative's card will also be mailed to your address. If you need a replacement card, follow the instructions included.

Recipients of SNAP are able to purchase unprepared fruits and vegetables from participating vendors at local farmers markets using their EBT card. Check for participating vendors by calling or looking for an EBT sign on display at vendors booths.

In order to continue to receive uninterrupted benefits you must reapply prior to the end of your certification period.

If you need free legal services, call this toll free number at 1-800-498-1804.

To request a fair hearing, call the county MDHS office at 601-362-9892 or fill out and return the form on the back of this notice.

Please read the back of this notice for your rights and responsibilities and reporting requirements for changes in household circumstances.

If you have questions contact your local county office at 601-362-9892 .
FOSTER

Để được giúp đỡ dịch thông báo này, hãy liên hệ với 1-800-948-4060.

REPORTING REQUIREMENTS FOR CHANGES IN HOUSEHOLD CIRCUMSTANCES: **10-01-2023**

Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) – You must report any of the following changes in the household: more than $125 in the amount of earned or unearned income; source of income; household composition; residence and any resulting changes in shelter costs; changes in the legal obligation to pay child support; a change in liquid resources, such as cash, stocks, bonds, and bank accounts. All changes must be reported within 10 days of the date the change becomes known to the household (TANF households must report within 5 days if the head of household moves out of state and when it is clear a child will be out of the home for more than 30 days). Additionally, all ABAWD households must report when their work hours fall below 20 hours per week, or an average of 80 hours monthly.

Note: If a SNAP household member receives lottery or gambling winnings equal to or greater than $4250, the household is ineligible to receive SNAP. Ineligibility continues as long as the household's resources exceed the resource limit.

SNAP/TANF Household Size and Gross Income Limits:

	1	2	3	4	5	6	7	8	9	10
SNAP	**$1580**	**$2137**	**$2694**	**$3250**	**$3807**	**$4364**	**$4921**	**$5478**	**$6035**	**$6592**
TANF	**$403**	**$542**	**$680**	**$819**	**$958**	**$1097**	**$1235**	**$1374**	**$1513**	**$1652**

Note: If there are more than ten (10) SNAP household members, add $557 for each one; for more than ten (10) TANF household members contact your worker for the total gross income level.

Note: Gross Income: (This is the amount before taxes and deductions are taken out.) Remember to add all income-wages, child support, social security, unemployment, etc. to compare to the amount on the chart above.

National Voter Registration Act:

If you or any member of your household needs assistance with registering to vote please contact your local county office.

SECTION I: TANF APPEAL AND FAIR HEARING RIGHTS

If we have denied your TANF application, closed your case or you are not satisfied with the amount of your TANF benefit, you may use the space in Section III below to request either an agency conference or state hearing to appeal our decision. If we don't hear from you, we will know that you understand the action taken and have no other information to give us.

You may request either an agency conference or state hearing within 90 days following the expiration of the advance notice period if your benefits were reduced or within 90 days of the date your case was denied or closed. If you request an agency conference and that decision is not in your favor, you may then request a state hearing. The Administrative Hearing Department may extend the time for filing the state hearing request if you can show good cause for not having made a timely appeal request.

If your hearing request is made within 10 days from the date of this notice and the request is based on factors other than a change in law or policy, or the expiration of the 60-month lifetime assistance period, your TANF benefits will be continued as they were prior to benefit reduction or case closure until there is a decision. If your benefits are continued and the hearing decision is not in your favor, you will have to repay the total of any benefits paid after the hearing request was made. If you do not request a hearing within 10 days from the date of this notice, your benefits cannot be continued pending a hearing decision. You may bring a lawyer, relative or friend to the hearing, or you may speak for yourself.

SECTION II: SNAP APPEAL AND FAIR HEARING RIGHTS

You have the right to request a hearing on any action by the agency or loss of benefits which occurred in the last 90 days. You may do this by contacting the local DHS office or by indicating your request for a hearing by signing your name below and returning this notice to the local office. Your case may be presented by a household member or a representative, such as legal counsel, a relative, a friend or other spokesperson.

If you request a hearing within 10 days from the date of this notice, you can receive SNAP until your hearing is decided or your certification period ends, whichever comes first. If, however, the hearing finds that our decision was correct, your household will owe us the value of the extra benefits you received. You can still request a hearing after 10 days, but you will not be able to receive SNAP at your current rate.

SECTION III: I want to request a hearing to discuss my ☐TANF ☐SNAP case.

The kind of hearing I want is: ☐An agency conference with a member of the county staff other than my worker.
☐ A state hearing with a state office staff member.

I want a hearing to discuss my ☐TANF and/or ☐SNAP case because _____.

☐ I do ☐ do not want my ☐TANF and/or ☐SNAP benefits to continue until the hearing is decided or my certification/review period ends.

I understand if I have not checked either block, this means I have chosen to have my benefits continue.

Signature _____ Date Signed _____

MISSISSIPPI
MDHS-EA-946
Revised 07-01-23
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FOR OFFICE USE ONLY:
Case Number:_____ Date Received:_____
How Received: ☐ Mail ☐ Fax ☐ Walk-In ☐ Telephone ☐ CWP
Received By: _____

MDHS
MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

CHANGE REPORTING FORM

All households are required to report the following changes in circumstances within 10 days of the date the change became known to the household:

- A change of more than $125 in the amount of unearned income.
- A change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income.
- A change of more than $125 in the amount of earned income from the amount last used to calculate the household's benefit amount as long as the household is certified for no longer than 6 months.
- A change in household composition, such as an addition or loss of a household member.
- A change in residence and the resulting change in shelter costs.
- A change in liquid resources that reaches or exceeds the limit for elderly and disabled households and all other households, unless excludable.
- A change in the legal obligation to pay child support.
- For able-bodied adults (ABAWDS) subject to the time limits, changes in work hours that cause an individual to be below 20 hours per week, averaged monthly.
- If a household member wins substantial lottery or gambling winnings.
- For TANF households, the parent/caretaker relative must report if the head of household moves out of state and when it becomes clear that a TANF child will be out of the home for more than thirty (30) days. Such a change in household composition must be reported within five (5) days.

If you need assistance in completing this form, please call Customer Service at 1-800-948-3050.

Name: **Case #:** **Phone #:**

☐ NEW ADDRESS/PHONE NUMBER CHANGES

Home Address: County:

Mailing Address:

Cell Phone Number: _____
Home Phone Number:_____

Email Address: _____

☐ EXPENSE CHANGES – Attach Verification

☐ Rent/Mortgage $_____ ☐ Lot Rent $_____

Attach proof of rent/mortgage such as lease agreement, rent receipt, mortgage statement etc.

If paid separately from your mortgage: ☐ Home Insurance $_____ ☐ Property Taxes $_____

Has the expense: ☐ Started ☐ Stopped ☐ Changed Date of change (mm/dd/yy): _____

How often billed: ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

Do you pay a heating and/or cooling expense? ☐ Yes ☐ No

Attach proof of utility expenses such as utility bills.

If you are not billed a heating and/or cooling expense, list the amounts you are billed, if any, for the following:

Electricity $_____ Gas $_____ Water $_____ Phone $_____ Garbage $_____ Other $_____

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

☐ Medical $_____ ***(Household member must be 60 or older or disabled to claim out of pocket medical expenses.)***

Attach proof of out-of-pocket medical costs such as current hospital bills, doctor bills, medical bills, pharmacy prescription printouts, etc.

☐ Drugs ☐ Medical/Dental ☐ Hospital Bills ☐ Nursing Care ☐ Medicare Premium ☐ Transportation

☐ Medical Supplies/Equipment ☐ Eyeglasses/Contacts ☐ Other Medical_____

☐ Has the expense: ☐ Started ☐Stopped ☐ Changed Date of change (mm/dd/yy): _____

How often billed: ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

☐Child Support $_____ ***(Must be court ordered and paid outside of the household.)***

Attach proof of child support expense paid outside of the household.

Has the expense: ☐ Started ☐ Stopped ☐ Changed Date of change (mm/dd/yy): _____

How often billed: ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

☐Child Care $_____

Attach proof of childcare expense from the childcare provider.

Has the expense: ☐Started ☐Stopped ☐Changed Date of change (mm/dd/yy): _____

How often billed: ☐Daily ☐Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

☐Other _____ $_____

Has the expense: ☐ Started ☐ Stopped ☐ Changed Date of change (mm/dd/yy): _____

How often billed: ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Name of Person Paying the Expense: _____

Will this change continue beyond the report month? ☐ Yes ☐ No

☐ INCOME CHANGES – Attach proof of income such as check stubs, employment verification form, etc.

Name of Person Receiving Income Change: _____

Will this continue beyond the report month? ☐ Yes ☐ No

Type of Income	Income	How Often Received	Total New Gross Per Pay Period
CHECK ONE BOX ONLY ☐Employment ☐ Pension ☐Unemployment ☐ Disability ☐Child Support ☐ Cash Gift ☐Other_____	**CHECK ONE BOX ONLY** ☐New ☐ Stopped ☐Increase ☐ Fired ☐Decrease ☐ Quit Date of change:_____	**CHECK ONE BOX ONLY** ☐Daily ☐ Weekly ☐Biweekly ☐Monthly ☐Semi-monthly	Amount $ Hours per week employed

Name of Person Receiving Income Change: _____

Will this continue beyond the report month? ☐ Yes ☐ No

CHECK ONE BOX ONLY ☐Employment ☐ Pension ☐Unemployment ☐ Disability ☐Child Support ☐ Cash Gift ☐Other_____	**CHECK ONE BOX ONLY** ☐New ☐ Stopped ☐Increase ☐ Fired ☐Decrease ☐ Quit Date of change:_____	**CHECK ONE BOX ONLY** ☐Daily ☐ Weekly ☐Biweekly ☐Monthly ☐Semi-monthly	Amount $ Hours per week employed

☐ RESOURCE CHANGES – Attach Verification

☐ Cash $_____ ☐ Stocks $_____ ☐ Bonds $_____ ☐ Bank Accounts $_____ ☐ Other $_____

Name of Person who Owns Resource: _____

Name of Institution: _____

☐ Cash $_____ ☐ Stocks $_____ ☐ Bonds $_____ ☐ Bank Accounts $_____ ☐ Other $_____

Name of Person who Owns Resource: _____

Name of Institution: _____

☐ Cash $_____ ☐ Stocks $_____ ☐ Bonds $_____ ☐ Bank Accounts $_____ ☐ Other $_____

Name of Person who Owns Resource: _____

Name of Institution: _____

☐ LOTTERY/GAMING WINNINGS – Attach Verification

Date Money Received: _____ Amount Received: $_____ Name of Winner: _____

HOUSEHOLD MEMBER CHANGES FOR ☐ SNAP ☐ TANF ☐ BOTH

PENALTY WARNING: *A Social Security Number (SSN) must be provided or applied for each person for whom assistance is requested per the Food and Nutrition Act of 2008. SSNs will be verified and used for Federal and State data matches, including but not limited to, Social Security, Internal Revenue Service, VA, MS Department of Employment Security, resource/income verifications, program disqualifications, and for collection of fraud debts. State and federal laws provide for fines, imprisonment or both for any person guilty of obtaining assistance to which he/she is not entitled by willfully withholding or giving false information. Information may be verified through collateral contacts when discrepancies are found. Alien status is subject to verification with United States Citizenship and Immigration Services (USCIS) and will require submission of certain information from this application to USCIS. Only US citizens and qualified aliens are eligible for SNAP benefits. Any non-citizens or non-qualified aliens may be left out of your case. Such persons will not be reported to the Immigration and Customs Enforcement agency. Non-citizens included in your case will have eligibility determined under SNAP rules. The income and resources of all persons in your household will be considered in determining eligibility for persons included in your case.

Name (Last, First)	Moved		Relationship to Head of Household	SS Number *See discussion above	Date of Birth	Age	Sex	**Optional		US Citizen Y or N
	In / Out	Date						Hispanic Y or N	*** Race Choose one or more	

**Information pertaining to Ethnicity and Race is not required and will not be used in determining your eligibility or benefit level. This information will be used to determine how effective the program is in reaching the eligible population.

*** Race Codes **AL** – American Indian/Alaska Native; **AS**-Asian; **BL**-Black or African American; **HP**-Hawaiian or Other Pacific Islander; **WH**-White; **OT**-Other

ADD A HOUSEHOLD MEMBER – For each child whose mother and/or father is absent from the home, enter the information below:

Child's Name	Absent Parent's Name	Absent Parent's Address	Absent Parent's SSN	Absent Parent's		
				DOB	Race	Sex

By signing and dating this form, I am giving consent for the attendance records of the children identified on this application to be disclosed by the Mississippi Department of Education to the Mississippi Department of Human Services for use by the Department of Human Services to determine compliance with school attendance requirements of the Temporary Assistance for Needy Families (TANF) Program. I certify that each person included in my household is a U.S. citizen or alien in lawful immigration status and that the information provided is true to the best of my knowledge. I give permission for the Department of Human Services to make a full review of my case and any necessary contacts to verify my statements. I know that I could be penalized if I knowingly give false information. I certify that I received the Rights and Responsibilities handout from this agency.

Signature of Applicant/Person Reporting the Change _____ Date _____

**Signature of Second Parent/TANF Payee *(if applicable)* _____ Date _____
(Required to add a household member to the TANF case)

Signature of Witness, if Signed by Mark _____ Date _____

VOTER REGISTRATION

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 a box, you will be considered to have decided not to register to vote at this time. 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 decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

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, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Mississippi Secretary of State, Elections Divisions, P.O. Box 136, Jackson, MS 39205-0136.

If you would like to request a voter registration form to be mailed to you, please call Customer Service at 1-800-948-3050.

PENALTY WARNING

SNAP PENALTY WARNING: If your household receives SNAP, it must follow the rules listed below. Any member of your household who breaks any of these rules on purpose can be barred from SNAP for 1 year for first offense, 2 years for second offense, and permanently for third offense; fined up to $250,000, and imprisoned up to 20 years or both; and subject to prosecution under other federal laws.

DO NOT give false information, or hide information to get or continue to get SNAP benefits. DO NOT trade or sell EBT cards. DO NOT alter EBT cards to get SNAP benefits you are not entitled to receive. DO NOT use SNAP benefits to buy ineligible items such as alcohol and tobacco or to pay food credit accounts. DO NOT use someone else's SNAP benefits or EBT card for your household. Individuals determined by a court to have committed the following program violations will be subject to the following penalties:

- **If you are found to have used or received benefits in a transaction involving the sale of a controlled substance, you will be ineligible to receive SNAP benefits for a period of two years for the first offense and permanently upon the second such offense.**
- **If you are found to have used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.**
- **If you have been found guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.**
- **If you have been found to have made a fraudulent statement or representation with respect to your identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in the Program for a period of 10 years.**

USDA NONDISCRIMINATION STATEMENT

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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.

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) 6190403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.