



PO BOX 83720  
BOISE, ID 83720-0026

<b>Case Number:</b>	<b>0562352</b>
Customer Name:	Angelique Stark
Phone:	(877) 456-1233
For the Hearing Impaired:	(800) 377-3529 (TTY)
Fax:	(866) 434-8278
E-mail:	MyBenefits@dhw.idaho.gov
Date of Notice:	July 06, 2023

Angelique K Stark  
700 N SHILLING AVE  
BLACKFOOT, ID 83221-1839

## News for your household:

We have completed your Food Stamps re-evaluation. Your household benefit amount beginning in August 2023 is \$740.00. Your new certification period is August 01, 2023 to January 31, 2024.

The following individuals are eligible for Food Stamps.

Name	Status
Piper Conan	Eligible
Paysn Conan	Eligible
Angelique Stark	Eligible

## More Information About Your Food Stamps:

Your monthly Food Stamps benefit will be available through Electronic Benefit Transfer (EBT) the 4<sup>th</sup> of each month.

If you have not already received your EBT card, you will receive it in the mail. If you have problems with your EBT Card, or to view your Quest Card account information, or change your PIN visit [www.idahoquestcard.com](http://www.idahoquestcard.com) or contact the Idaho EBT Customer Service Center at (888) 432-4328.

**The information you reported that we considered in your benefit determination is summarized below.**

### Income:

You have not reported any income.

### Expenses:

Angelique Stark is paying: \$750.00 rent per month.

You have a cost for heating or cooling expenses.

There are no other expenses claimed for your household.

### Property:

Angelique Stark reported: checking account with a value of \$0.00, automobile with a value of \$5,500.00, automobile with a value of \$1,000.00, checking account with a value of \$0.00, savings/credit union account with a value of \$0.00.

There are no other property/resources claimed for your household.

## Next Steps:

Please review the information on this notice to ensure it is accurate. If it is not, contact us within 10 days of the date of this notice to provide the corrected information.

If you also applied for cash assistance, and it has not yet been approved, your Food Stamp benefits may be reduced or stopped without another notice if your cash aid is approved.

If you disagree with this determination, review Your Hearing Rights on the back of the first page.

# Your rights

## Accessibility and interpretation services

The Idaho Department of Health and Welfare (IDHW) offers the following services free to you. Please ask if you need the following assistance to communicate more effectively with us:

- Assistance in understanding this form
- Accommodation for a disability
- Language Interpreter

To access any of these services, please call: 1-877-456-1233 or 1-800-377-3529 (TTY) for those with a hearing impairment.

## Appeal/Hearing

You have the right to ask for a hearing if you disagree with IDHW's action. You have 90 days to ask for a hearing for Food Stamps, and 30 days for Temporary Aid for Families in Idaho (TAFI), Idaho Child Care Program (ICCP), Aid to the Aged/Blind/Disabled (AABD) Cash, and Medicaid. These timeframes start the day after IDHW gave or mailed you the notice of this decision. In certain instances, you may be eligible to continue receiving your benefits while your appeal is being considered. If your appeal is denied, you will be liable to repay any benefits received during this period. If you are interested in pursuing this option, your appeal must be received within ten (10) days of this notice. Please ask about this option when requesting an appeal.

Please be advised that a reevaluation of eligibility will be assessed for all members of the household at the time this appeal is considered.

To request a hearing or a legal aid referral, call 1-877-456-1233, email us at [mybenefits@dhw.idaho.gov](mailto:mybenefits@dhw.idaho.gov), or fill out and submit the Fair Hearing Request Form at [mybenefitforms.dhw.idaho.gov](http://mybenefitforms.dhw.idaho.gov). At the hearing, you may represent yourself, use legal counsel, a relative, a friend, or other spokesperson.

## Discrimination

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, IDHW is prohibited from discriminating, excluding people, or treating them differently on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. If you believe you have been discriminated against, please contact HHS, USDA or IDHW at:

U.S. Department of Health and Human Services  
200 Independence Ave, SW Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019 (Voice)  
1-800-537-7679 (TTY)

USDA Office of Adjudication  
1400 Independence Ave. S.W.  
Washington, D.C. 20250-9410  
1-800-795-3272 (Voice)  
1-800-877-8339 (TTY)

Idaho Department of Health and Welfare  
Civil Rights Manager  
P.O. Box 83720  
Boise, ID 83720-0036

For more information about the Idaho Department of Health and Welfare's nondiscrimination policy, visit:  
[healthandwelfare.idaho.gov](http://healthandwelfare.idaho.gov)

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-456-1233 (TTY: 1-800-377-3529).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-456-1233 (TTY: 1-800-377-3529)。
Srpsko-hrvatski (Serbo- Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-456-1233 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-3529).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-456-1233 (TTY: 1-800-377-3529)번으로 전화해 주십시오.
नेपाल (Nepali)	ध्यान दिनुहोस्: तपाइंले नेपाली बोलुनुहुन्छ भने तपाइंको निमित्त भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877-456-1233 (टि टाईप: 1-800-377-3529) ।
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-456-1233 (TTY: 1-800-377-3529)
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-456-1233 (رقم هاتف الصم والبكم: 1-800-377-3529).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-456-1233 (TTY: 1-800-377-3529).
Tagalog (Tagalog/ Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-456-1233 (TTY: 1-800-377-3529).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-456-1233 (телетайп: 1-800-377-3529).
Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-456-1233 (TTY: 1-800-377-3529).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-456-1233 (TTY: 1-800-377-3529) まで、お電話にてご連絡ください。
Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-456-1233 (TTY: 1-800-377-3529).
Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-877-456-1233 (TTY: 1-800-377-3529).
فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان 1233-456-877-1-1 بکیرید تماس (TTY: 1-800-377-3529) یا. باشد می ف

## Questions?

If you have questions about the information in this notice you can call us toll free at (877) 456-1233, for hearing impaired (888) 791-3004, Monday through Friday 8:00am – 5:00pm.

If you have questions about other programs and services, contact the **2-1-1 CareLine Program**. This program provides statewide community information and referrals for a variety of Health and Human Services Programs dedicated to helping Idaho residents. You can contact the **2-1-1 CareLine** for more information by dialing 211 or (800) 926-2588.



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DEPT H & W-CENTRAL OFFICE  
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## Change Report Form

HW0592  
Rev 06/2022

### Submit this form only when you have a change to report

To ensure you receive the correct benefit, please report changes in your situation. You can report a change on your idalink account at [idalink.idaho.gov](http://idalink.idaho.gov). You can also report a change using this form, calling IDHW, or visiting a local IDHW office.

### Important: Attach proof of the changes you are reporting

#### Use this form to report a change

1. Complete all fields
2. Sign the form
3. Mail to address above or return the form to IDHW.

#### Contact the Department

**Phone:** 1-877-456-1233

**Fax:** 1-866-434-8278

**Email:** [mybenefits@dhw.idaho.gov](mailto:mybenefits@dhw.idaho.gov)

**Local office:** [healthandwelfare.idaho.gov](http://healthandwelfare.idaho.gov)

First Name	Middle Name	Last Name	Case number or Social Security Number
Daytime Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	If none, where can we leave a message?	

Briefly describe what changed:

Date change occurred or will occur:	Will this change continue next month? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe why not:
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### Signature (must be completed)

Failure to accurately report changes in your situation may result in a loss or reduction of benefits and legal action to recover overpayments. Under penalty of perjury, I swear or affirm that the information I provide is true and complete.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

### If any member of your household receives Medicaid, answer the following questions:

1. Tell us the total amount of all earned and unearned income your household receives for the current year (January-December)

**Include:** Wages, salary, tips, self-employment, rental, retirement, unemployment, disability, and tribal gaming payments,

**NOTE:** DO NOT include Social Security survivors, SSI, or other tribal income. \$ \_\_\_\_\_

2. Tell us the total amount of Social Security disability or Social Security income your household receives for the current year (January-December). \$ \_\_\_\_\_

### Important: Please Attach Proof of Your Changes

**Directions:** Use the following table to identify which changes to report depending on the type of benefits you receive. If you have questions, please call your local Health and Welfare office.

Report These Changes					
Report the changes listed in this column	Food Stamps	Medicaid/ CHIP or AABD Cash	Child Care	Temporary Cash Assistance for Families (TAFI)	Nursing Home, Home based Services, Assisted Living
Increases to your income					X
A new address		X	X	X	X
Change in child care provider			X		
When someone leaves or joins your household		X	X	X	
Change in activity hours from part time to full time OR full time to part time			X		
Activity hours change to zero			X		
If your out of pocket medical expenses decreases					X
If your income increases over the stated limit for your program	X	X	X	X	X
When a household member between age 18 and 49, who does not have a minor child in the home, begins working less than 80 hours per month.	X				

### Current Monthly Income Limits for Food Stamps

Household Size	Gross Income Limit
1	\$1,473
2	\$1,984
3	\$2,495
4	\$3,007
5	\$3,518
6	\$4,029
7	\$4,541
8	\$5,052
9	\$5,564
10	\$6,076
Each Additional	+ \$512