DSS Street Address:

Case Identifier:
Worker:
Date Generated:
Due Date:

DSS Mailing address:

Client Name:
Mailing Address:

North Carolina Department of Health and Human Services
Division of Social Services (DSS)

Food and Nutrition Services (FNS) Notice of Expiration and Interview Recertification Form

Your FNS benefits will stop on _____. You may be able to continue to get FNS benefits after that date if you fill out this form and return it to us no later than_____.

What do I need to do with this form?

You or your authorized representative must complete this entire form, sign and date the last page. You have the right to receive an application upon request. If you cannot complete this form you will only need to provide a signature, legible name, and address. Bring, mail to us at the above address, fax _____or complete application online https://epass.nc.gov/CitizenPortal/application.do.
Any household that only has Supplemental Security Income (SSI) can apply for recertification at the Social Security office. If you are applying for Food and Nutrition Services (FNS) and SSI at the same time from an Institution, the filing date is the date you are released from the Institution. If a signed form is incomplete, your FNS worker will contact you to get more information.

You are responsible for providing required verification information. The information on this form and information obtained from other sources may cause your benefits to stop or change.

YOU MUST BE INTERVIEWED. BENEFITS WILL NOT BE ISSUED WITHOUT AN INTERVIEW. Your caseworker will schedule your interview appointment. Failure to attend an interview may result in denial or delay of benefits. You are responsible for rescheduling a missed interview.

If you have questions or need help completing this form, call _____ or call the DHHS Customer Services Center at 1-800-662-7030 or 1-877-452-2514 (TTY Dedicated).

- An interpreter can be provided, free of charge, if you need assistance in applying.
- Please make sure the address of the local agency shows through the window of the enclosed return envelope.
- **Do not return this form before the first day of** _____.
- Attach verifications for the month of _____.

Information about Social Security Numbers, US Citizenship and Immigration

You can choose not to apply for benefits for yourself or members of your household and are not required to answer questions about Social Security Numbers (SSNs) and citizenship/immigration information for those you choose not to apply for. For each individual that you are applying for, you must provide information about SSNs and citizenship/immigration status. Providing a SSN is required by the Food and Nutrition Act for applicants seeking benefits. We will only use the SSNs you give us to do computer matches and check what you told us with State and Federal Agencies. You must be a United States (U.S.) citizen or an eligible alien and also meet other Food and Nutrition Services rules to get Food and Nutrition Services benefits. We will only contact US Citizenship and Immigration Service (USCIS) to check the immigration status on the household members who give us their immigration documents. If an applicant does not provide this information, they will be ineligible for benefits. By signing this form, it states, under penalty of perjury I have given correct information on the citizenship/alien status of all individuals applied for. Household members must provide their financial information because it is needed to determine eligibility for individuals who are applying. Eligible household members who apply will be able to get benefits even though some people in the household are not applying for benefits. The amount of benefits will depend on the number of people requesting benefits.

START HERE

A. Tell us how to reach you.

First Name **Middle Initial** **Last Name**		**Mailing Address (House/Apt. #, Street, City, State, Zip Code)**	
Residence Address (House/Apt. #, Street, City, State, Zip Code) (if different from mailing address)	**Home Phone**	**Cell Phone**	**Message Number**
Your Signature or Authorized Representative	**Date Signed**	**Telephone Company Provider**	**Language You Speak**

B. List everyone who lives with you below. (Attach another sheet if needed)

Name *(First, Middle Initial, & Last)*	Relation -ship to You	Date of Birth	Age/ Sex	**Lives in a Homeless Shelter or on the Street (Yes/No)	Applying for Benefits? Yes/No	*Optional Social Security Number	*Optional U.S. Citizen Yes/No	*Optional Race	*Optional Hispanic or Latino Yes/No	Buy & Cook Together? Yes/No
	Self									

*Social Security Numbers and Citizenship information are not needed for those not applying for benefits.
*Eligibility or level of benefits are not affected if ethnicity or race is not answered. When the information is not provided the agency will collect the information by observation during the interview. Giving this information will help ensure program benefits are distributed without regard to race, color, or national origin (this information is used for statistical purposes only).
*Race Choose one or more numbers that apply and enter above:
1-American Indian/Alaskan Native, 2-Asian, 3-Black/African American, 4-Native Hawaiian/Other Pacific Island and 5-White

**** These questions may assist in identifying Able-Bodied Adults without Dependents (ABAWD). Please answer these questions about any activity within the last 6 months.**

C. Tell us about your finances.

**1. Does anyone in your household work? ❑Yes ❑ No If yes, complete below.

**2. Is anyone in your household getting ready to start a job? ❑Yes ❑ No If yes, expected start date_____ and complete below.

Attach all income verification pay received during the month listed on Page 1. If you are paid monthly, attach income verification for the month listed on Page 1. If you are self-employed, attach last year's federal tax forms and include all schedules. If tax forms for last year are not available attach your business records and receipts for business expenses for the previous 12 months. If it is new employment, attach verification for all pay received so far.

If you do not have all your check stubs, you may have your employer complete the employer verification section below. (Attach another sheet if needed)

Name of Person Working:			**How Often Paid: (weekly/month, etc.)**		
Employer Name:			**Employer Phone Number:**		
Date Pay Received (month & day)	**Number of Hours**	**Rate of Pay**	**Bonus or Vacation Pay**	**Gross Pay**	**Tips**
Employer Signature:		**Employer Title:**		**Date Signed:**	

**3. Has anyone in your household stopped working within the last 6 months? ❑Yes ❑ No If yes, who stopped working? _____
Reason? _____Date last worked? _____ Date of last pay? _____ Total hours worked in last 30 days? _____

**4. Does anyone in your household get money other than from work? ❑Yes ❑ No If yes, complete below and attach verification for month listed on page 1. Examples: Cash, Contributions, Work First, Child Support, Unemployment Benefits, Social Security, SSI, Worker's Compensation, Veteran's Benefits, etc. (attach another sheet if needed)

Name	Type of Income	Person or Organization That Gives the Money	Phone Number and Address of Person or Organization	Amount of Income (before taxes)	How Often?

**5. Does anyone work as a volunteer or participate in a work training program? ❑Yes ❑ No If yes, complete below.

Name	Name of Volunteer Site or Work Training Program	Site Address and Phone Number	Start Date	End Date	Hours Per Week

6. Does anyone own or jointly own any assets including a non household member(s)? ❑Yes ❑ No If yes, complete below.
We will determine if verification is needed and if it is accessible to you. (Attach another sheet if needed)

Name (Who Owns it?)	Type of Asset	How Much or Value of Asset?	Where Do You Keep This Asset and What is the Account Number?
	Cash on Hand		
	Checking Account		
	Savings Account		
	Other		

D. Tell us about your expenses.

❑Yes ❑ No	Do you pay rent or mortgage where you live? If yes, how much do you pay out of your pocket each month? $_____
❑Yes ❑ No	Do you receive assistance paying your rent? If yes, check any you received ❑ HUD ❑ Section 8 ❑ Public Housing
❑ Yes ❑No	Do you pay any other expenses where you live? If yes, check the expense and enter the monthly amount: ❑Lot Rent $_____ ❑Property Taxes (if paid separately) $_____ ❑Other (list type) $ _____ ❑Homeowner's dues (if paid separately) $_____❑Homeowners Insurance (if paid separately) $ _____
❑ Yes ❑No	Are you responsible for paying any utility bills separate from your rent? If yes, check all that apply. ❑ Heat ❑Kerosene ❑Fuel Oil ❑Electricity ❑ Coal ❑ Wood ❑ Natural Gas ❑ LP Gas ❑Telephone/Cell Phone ❑ Water/Sewage ❑Garbage/Trash ❑ Utility Excess (Public Housing) How do you heat your home? _____ How do you cool your home? _____
❑ Yes ❑ No	Does anyone help pay your bills? If yes, who helps?_____how much? $_____.
❑ Yes ❑ No	Did you get a Low Income Energy Assistance Program (LIEAP) check at your current residence within the past 12 months?
❑Yes ❑ No	Is your household responsible for paying any child care or disabled adult care? If yes, who receives care:_____. who pays:_____ amount per month_____. Name and phone number of care provider? Child/adult care expenses?
❑ Yes ❑ No	Does anyone age 60 or over, or anyone receiving disability benefits, have out-of-pocket medical expenses over $35 monthly? This includes Medicare or Health Insurance and transportation cost for medical care. If yes, do you wish to claim a deduction for these expenses ❑ Yes ❑ No If yes, to get this deduction you must attach receipts or a computer printout of your expenses.
❑ Yes ❑ No	Does your household pay court ordered child support for children outside your home (include court ordered health insurance payments)? If yes, who pays the child support?_____. Who is it paid to?_____ Child's name?_____. Amount you pay? _____ How often? _____

E. Tell us about the people in your home.

7. Please answer the following questions for everyone in your household:

❑Yes ❑ No	Is anyone in your household age 16 or older attending school at least half time now or have they in the last 6 months? If yes, list the person's name and school they attend:
❑Yes ❑ No	Does anyone in your household have a felony drug conviction or controlled substance after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:
❑ Yes ❑No	Is anyone in your household in violation of probation or parole or running from the law to avoid felony prosecution? If yes tell us his/her name, date, type, and place of conviction:
❑ Yes ❑No	Have you or any member of your household been convicted of trading benefits for drugs after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:
❑Yes ❑No	Have you or any member of your household been convicted of buying or selling benefits $500 or more after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:
❑ Yes ❑ No	Have you or any member of your household been convicted of fraudulently receiving duplicate benefits in any State after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:

❑ Yes ❑ No	Have you or any member of your household been convicted of trading benefits for guns, ammunitions, or explosives after August 22, 1996? If yes tell us his/her name, date, type, and place of conviction:
❑Yes ❑No	Is anyone in your household physically or mentally unfit for employment? If yes, who and what months?
❑ Yes ❑ No	Does anyone operate a Home School at least 30 hours a week? If yes, who and what months?
❑Yes ❑ No	Does anyone care for an incapacitated person (does not have to live in the home)? If yes, who and what months?
❑ Yes ❑ No	Does anyone participate in an official Refugee Employment Program? If yes, who and what months?
❑ Yes ❑ No	Is anyone in the household unable to work due to alcohol and/or drug addiction? If yes, who and what months?
❑Yes ❑ No	Is anyone in a drug or alcohol treatment program? If yes, who and what months?
❑Yes ❑ No	Is anyone in the household pregnant? If yes, who? _____

Authorized Representative

Do you need someone to help you get and/or use your Food and Nutrition Services benefits? ❑ Yes ❑ No If yes, please list that person's name_____. If you checked **Yes** above, we will give or mail you a form. You and the person you want to help can complete the form and return it to our office. This person will receive an EBT card and will have access to your Food and Nutrition Services Benefits. If you already have an authorized representative, do you want them to continue? ❑ Yes ❑ No Authorized Representative Name: _____

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 either box, you will be considered to have decided not to register to vote at this time.

How to Get a Fair Hearing

You have the right to ask for a hearing in person, by telephone or in writing, if you think your case is wrong. You have 90 calendar days to ask for a hearing. Unless you ask for a hearing by then, you cannot have one. A household member or someone else such as a lawyer, friend, or relative can represent you at a fair hearing. Free legal advice may be available. Contact Legal Aid of North Carolina office at 1-866-219-5262, Street: 224 South Dawson St. Raleigh, NC 27601, Mailing: PO Box 26087 Raleigh, NC 27611.

Your Signature and Statement of Understanding

I understand that my signature authorizes federal, state, and local officials to contact other persons or organizations to verify the information I have provided. Do not lie or hide information to get benefits that your household should not get. I have given correct information on the citizenship/immigration status of all individuals applied for. If a law enforcement officer requests the address, social security numbers, or photographs in your file to assist in locating fugitive felons or probation/parole violators, the agency must provide this information.

Any member who intentionally breaks any of the rules, may not be able to get Food and Nutrition Services for one year for the first violation, two years for second the violation, and permanently for third the violation. 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 not be eligible for benefits for two years for the first violation, and permanently for the second violation. You may also be fined up to $250,000 and/or jailed up to 20 years. If court ordered you may also be ineligible from the Food and Nutrition Services program for an additional 18 months. If a court finds you guilty of having trafficked benefits for $500 or more, or trading benefits for firearms, ammunition or explosives you will be permanently ineligible for Food and Nutrition Services. If you use your food assistance benefits to buy nonfood items, trade, or sell your benefits, pay on credit accounts, take someone's EBT card without authorization or let someone use yours, you will lose your benefits.

I acknowledge that I have received an explanation of my right to an income deduction for Food and Nutrition Services benefits for any of the following items: Child/adult care expenses, medical expenses, shelter expenses, utility expenses, and operational expenses for self-employment. I understand that if I fail to report or verify any of the above listed expenses, I will give up my right to receive a deduction for these expense(s).

First Name	Middle Initial	Last Name		
Mailing Address (House/Apt. #/Street)		City	State	Zip Code
Home Phone	Cell Phone	Message Number	Telephone Company Provider	Language you speak
Your Signature or Authorized Representative		Date Signed		
Witness Signature (if signature is an X)		Date Signed		
****AGENCY USE ONLY****				
Required Caseworker Signature		Date of Interview	❑ Telephone	❑ Office visit

For information regarding the Teen Pregnancy Prevention Initiative contact your local Health Department or call the DHHS Customer Service Center at 1- 800-662-7030. For information regarding services provided for Healthy Marriages contact your local agency.