



Revised August 2020

Supplemental Nutrition Assistance Program (SNAP) CHANGE REPORT FORM

PLEASE FILL OUT SECTION IN THE CHART BELOW

<p>Date: _____</p> <p>Case Name: _____</p> <p>Case Number: _____</p> <p>Contact No: _____</p> <p>Email Address: _____</p> <p>Mailing Address: _____</p> <p>_____</p>	<p>SI USTED NO ENTIENDE ESTA FORMA O NECESITA AYUDA LLAME SU OFICINA LOCAL DE DERTIFICACION.</p> <p>DISTRICT OFFICES ARE LOCATED AT</p> <p>ST. THOMAS -1303 Hospital Ground, STE.1 VI, 00802 Phone No.: 340-774-2399 - Fax No: 340-774-2399 Email: certoffice.stt@dhs.vi.gov</p> <p>ST. JOHN- Human Services Multi-Purpose Bld., Cruz Bay, VI 00830 Phone No.: 340-776-6334/5 Email: certoffice.stt@dhs.vi.gov</p> <p>ST. CROIX- 4201 Mars Hill, Frederiksted, VI 00840 Phone No.: 340-772-7100 - Fax No.: 340-772-9591 Email: certoffice.stx@dhs.vi.gov</p>
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ATTENTION: This form can be used to report mandatory or voluntary changes in your household circumstances.
The only mandatory changes that households are required to report is:

1. **If the household, at time of application or recertification, was certified at or below the 130% poverty gross income limit based on household family size, and the new monthly gross income exceeds.**
 - a. If the household's gross income was greater at time of application or recertification the household does not have to report the increase in income. See income chart below.
2. **If any member of the household received a single winning of \$3,500 or greater from lottery or gambling.**

ALL OTHER CHANGES ARE OPTIONAL AND VOLUNTARY, however, once this form is received by the office, the office will act on the changes reported. Households are encouraged to report any changes that the household believes would increase the household's SNAP benefits.

Number of persons you get SNAP for (to include disqualified member)	130% Poverty Gross Income Limit
1	\$1,383
2	\$1,868
3	\$2,353
4	\$2,839
5	\$3,324
6	\$3,809
7	\$4,295
8	\$4,780
9	\$5,266
10	\$5,752
Each additional person add:	\$486

Complete the section(s) that pertains to the change(s) your household is reporting and attached the supporting documents, where necessary.

CHANGES IN HOUSEHOLD COMPOSITION

<u>Name of household member</u>	<u>Left</u>	<u>Entered household</u>	<u>Elderly or disabled</u>	
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CHANGES IN HOUSEHOLD'S INCOME OR SOURCE OF INCOME

<u>Name of household member</u>	<u>Source of income</u>	<u>New Amount</u>
1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____

NEW SOCIAL SECURITY NUMBER

<u>Name</u>	<u>Social Security number</u>
1. _____	_____ _____ _____
2. _____	_____ _____ _____
3. _____	_____ _____ _____

CHANGES IN RENT OR MORTGAGE

<u>If the household moved, what is new address</u>		<u>City</u>	<u>State</u>	<u>Zip Code</u>
_____		_____	_____	_____
<u>If you don't have a street address, tell us how to get to your home reached</u>		<u>Telephone number where you can be reached</u>		
_____		_____		
<u>Rent or mortgage payment</u>	<u>Insurance on home (if not included in mortgage)</u>	<u>Property taxes (if not included in mortgage)</u>		
<u>New amount</u>	<u>\$</u>	<u>\$</u>	<u>\$</u>	_____

Are you a boarder? (A boarder pays a reasonable rate for lodging and at least two meals per day)

Yes ☐ NO ☐

CHANGES IN UTILITIES OR DEPENDENT CARE COSTS

<u>List Utility or dependent care</u>	<u>New amount</u>	<u>How often billed</u>
_____	\$ _____	_____ _____
_____	\$ _____	_____ _____
_____	\$ _____	_____ _____

CHANGES IN MEDICAL EXPENSES FOR ELDERLY OR DISABLED HOUSEHOLD MEMBER

List Name of Elderly or Disabled Household Member

Type of Medical Expenses Amount How often are you billed?

1. _____
2. _____
3. _____
4. _____

ACQUISITION/SOLD OR TRADE OF VEHICLES OR ASSETS

Has any household member who has been disqualified for intentional program violation acquired, sold or trade a car/truck, boat, camper, motorcycle or other assets such as property or land?

Vehicle Make _____ Model _____ Year _____
Value from sale or trade: \$ _____

CHANGES IN RESOURCES (SAVINGS, CHECKING, CDS, ETC.)

List resources of any household member who has been disqualified for intentional program violation

Type of resources: _____

Value of resources: _____

SINGLE WINNINGS OF \$3,500 OR GREATER FROM LOTTERY OR GAMBLING

Name of household member: _____

Gross amount of winnings before deductions: _____

Date of winnings: _____

Use this section for additional space, if needed, to report other changes household decides to report :

Do you expect the changes you have reported on this form to remain the same for the next 30 days?

Yes ☐ No ☐ If you answered no, please explain:

IF YOUR BENEFITS CHANGE

We will use your information reported on this form to determine if your household's benefits will change. Before we change your benefits amount, we will send you a notice explaining what will happen. If you do not agree with our decision, you can request a fair hearing, and request that your benefits remain unchanged pending the hearing. However, should the hearing officer rule against the household, the household will have to repay any benefits receive that it was not entitled to.

PENALTY WARNING

IF ANY INFORMATION GIVEN BY YOU IS FOUND TO BE INCORRECT, THE SNAP HOUSEHOLD MAY BE DENIED SNAP BENEFITS. IF YOU, AN ADULT HOUSEHOLD MEMBER, OR THE HOUSEHOLD'S AUTHORIZE REPRESENTATIVE GIVE US FALSE INFORMATION ON PURPOSE, LEGAL ACTION MAY BE TAKEN AGAINST YOU OR YOUR HOUSEHOLD. YOU OR ANY ADULT MEMBER OF YOUR HOUSEHOLD MAY ALSO HAVE TO PAY BACK THE AMOUNT OF BENEFITS THAT THE HOUSEHOLD SHOULD NOT HAVE RECEIVED. IF YOUR HOUSEHOLD GET SNAP YOU MUST FOLLOW THE RULES LISTED BELOW. ANY ADULT HOUSEHOLD MEMBER FOUND GUILTY BY A COURT OR AN ADMINISTRATIVE DISQUALIFICATION HEARING OF BREAKING ANY OF THE FOLLOWING RULES OR WHO SIGNS A VOLUNTARY DISQUALIFICATION CONSENT AGREEMENT OR WAIVER OF AN ADMINISTRATION DISQUALIFICATION HEARING WILL BE BARRED FROM GETTING SNAP BENEFITS FOR: ONE YEAR FOR THE FIRST VIOLATION, TWO YEARS FOR THE SECOND VIOLATION, AND PERMANENTLY FOR THE THIRD VIOLATION.

- DO NOT give false or incomplete information or hide information to get or continue to get SNAP.
 - DO NOT use SNAP benefits to buy ineligible items, such as alcohol drinks, and tobacco.
 - DO NOT use someone else's SNAP EBT Card for your household.
 - DO NOT use your SNAP EBT card to purchase food on credit.
 - DO NOT attempt to buy or sell your SNAP benefits.
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I understand the penalty for hiding or giving false information, I also understand the household will owe the value of any extra SNAP received because I did not report the mandatory changes required to report. I agree to prove any changes reported, if asked. My answers on this form are correct and complete to the best of my knowledge.

Print Name: _____

Signature: _____ **Date:** _____

Identify your relationship to household:

- ☐ Household Head
 - ☐ Household Member
 - ☐ Household's Authorized Representative
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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, 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.
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For office use only:

Worker's Name _____

Signature: _____

Date: _____