Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING
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POLICY BULLETIN #16-60-OPE

INFORMATION VERIFICATION SERVICE (IVS) COMPUTER MATCH PROCESSING DESK GUIDE

Date: Aug 11, 2016	**Subtopic(s):** SNAP Periodic Reports
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to introduce the new Information Verification Service (IVS) Computer Match Processing Desk Guide (**FIA-1170**) to Mailer and Match Action Program (MMAP) staff participating in the IVS pilot program which began on May 31, 2016. Information Verification Service (IVS) The Information Verification Service is a new web application that retrieves and stores data from multiple computer matches and presents this information in a single consolidated interface. The single interface reduces the time needed to access and retrieve match information. The IVS displays multi-source information in a uniform format that facilitates comparison and analysis of match data and case-related information. The IVS also maintains a historical record of match information retrieved. This record permits the viewing of each previous match result produced and eliminates the need for staff to scan and index computer match results in the case record. The availability of previous match results in the IVS permits supervisors, auditors, and oversight agencies to view the same exact match information used by staff in taking a case action. IVS Pilot MMAP staff that is participating in the pilot will use the IVS to verify case information reported by Supplemental Nutrition Assistance Program (SNAP) participants in the Periodic Report (**LDSS-4310**) and the Follow-up to the Periodic Report (**LDSS-4310A**).
For information about Change reporting rules and Periodic Reports, see PD #12-16-ELI.	

Computer Matches included in the IVS Pilot

At the start of the pilot, the IVS included data from TALX, NYC Employee, Automated Child Care Information System (ACCIS), and the Child Support Income computer match databases. Data from additional computer matches will be added to the IVS as its development and implementation are expanded.

For information about the TALX matches, see PD #11-11-EMP.

TALX/The Work Number Service is an employment verification service which provides employment and income verification of employees of companies that register with the TALX Corporation. The NYC Employee computer match provides employment and income verification of individuals employed by the government of the City of New York. ACCIS is a child care management and payment system utilized by the Human Resources Administration (HRA) and the Administration for Children's Services (ACS). The ACCIS computer match provides employment and income verification of child care providers who are registered in the system. The Child Support Income computer match provides verification of child support payments received by households through the HRA Office of Child Support Enforcement (OCSE).

For information about ACCIS matches, see PD #13-22-ELI.

For information about Child Support Income matches, see PD 15-13-SYS.
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IVS Computer Match Processing Desk Guide

The IVS Computer Match Processing Desk Guide (**FIA-1170**) is a tool to assist staff verifying client information received in the **LDSS-4310** or **LDSS-4310A.** The Desk Guide presents certain scenarios in tabular form that involve comparisons of information received in the Periodic Report against computer match results posted in the IVS. Instructions are provided for general actions to take when discrepancies arise between the Periodic Report and computer match results or when both sources of information are consistent.

The Desk Guide includes the following headings:

- Computer Match – Indicates the name(s) of the computer match source(s),
- Eligibility Factors - Lists those eligibility factors that can be affected by the computer match information,
- Verified Upon Receipt? – Specifies whether or not computer match information is considered verified upon receipt,
- Comparison of Periodic Report and Match Results – Displays scenarios involving case information reported in the Periodic Report (**LDSS-4310**) compared against match results in the IVS,

For more information about computer match information that is "verified upon receipt" see PD #10-30-OPE.

- Instructions/Annotations – Provides information about actions to take in response to scenarios given under “Comparison of Periodic Report and Match Results”,
- Additional Notes-Includes added details or instructions about IVS computer match information and/or processing.

Effective Immediately

Related Items:

PD #10-30-OPE	Clarification Regarding Computer Matches
PD #11-11-EMP	TALX/ The Work Number Service
PD #12-16-ELI	Food Stamp Change Reporting Rules and Periodic Reporting
PD #13-22-ELI	Supplemental Nutrition Assistance Program (SNAP) Child Care Providers in the Automated Child Care Information System (ACCIS) Match in the Paperless Office System (POS)
PD #15-13-SYS	Child Support Income Match for Non-Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP)

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Attachments:

FIA-1170	Information Verification Service (IVS) –Computer Match Processing Desk Guide
LDSS-4310	Periodic Report – Supplemental Nutrition Assistance Program (SNAP) (Rev. 10/15)
LDSS-4310-SP	Periodic Report – Supplemental Nutrition Assistance Program (SNAP) (Spanish) (Rev. 1/13)
LDSS-4310A	Follow-up to the Periodic Report (Rev. 10/15)
LDSS-4310A-SP	Follow-up to the Periodic Report (Spanish) (Rev. 6/14)

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Information Verification Service (IVS) - Computer Match Processing Desk Guide

Computer Match:	TALX[1], NYC Employee, ACCIS Childcare Provider Income		
Eligibility Factor(s)	**Verified Upon Receipt?**	**Comparison of Periodic Report & Match Results**	**Instructions/Annotations**
		Periodic Report (LDSS-4310) / **Match Result**	
Earned Income	Yes	No change in Income or Job reported Change in Income or Job reported Income (Gross Amount) and Employer's Information in Match consistent with **LDSS-4310**/Case Information.	Income/Employment Information is verified; no document request is needed for the eligibility factor. If there is a change in income, budget income, per current procedures, and send notification of action taken on case, as required. If there is a loss of hours and the individual is subject to SNAP work requirements, check that s/he is not subject to a Voluntary Quit sanction.
Earned Income	Yes	No change in Income or Job Change in Income or Job reported a) Income (Gross Amount) in Match is More or Less than Income reported on **LDSS-4310** or in Case Information b) New Income/Job on Match not reported on **LDSS-4310** or in Case Information.	(a/b) Budget income, per current procedure, and send notification of action taken on case, as required. If there is a loss of hours and the individual is subject to SNAP work requirements, check that s/he is not subject to a Voluntary Quit sanction.
Earned Income	Yes	Loss of Job reported Employee Status and Income in Match is consistent with **LDSS-4310**.	Loss of Employment is verified; no document request is needed for the eligibility factor. Budget income, per current procedures, and send notification of action taken on case, as required. However, if the individual is subject to SNAP work requirements, check that s/he is not subject to a Voluntary Quit sanction.
TALX : Able-Bodied Adult Without Dependents (ABAWD) Eligibility (Income and work hours only)	Yes	No report of work activity under 80 hours per month for able-bodied adult in H/H without child under 18. a) Hours worked per month when calculated indicate H/H member works at least 80 hour per month. b) Hours worked per month and/or income when calculated indicate H/H member DOES NOT work at least 80 hour per month or meet ABAWD income minimum.	a) ABAWD work hours are verified. (a/b) Worker should review work hours and income to see if change is needed in SNAP Employment Status Code and ABAWD indicator code. Question of ABAWD eligibility should be addressed at next recertification. If there is a change in income, budget income, per current procedures, and send notification of action taken on case, as required. If there is a loss of hours and the individual is subject to SNAP work requirements, check that s/he is not subject to a Voluntary Quit sanction.

Information Verification Service (IVS) - Computer Match Processing Desk Guide

Computer Match:	**TALX[1], NYC Employee, ACCIS Childcare Provider Income *(continued)***		
Eligibility Factor(s)	**Verified Upon Receipt?**	**Comparison of Periodic Report & Match Results**	**Instructions/Annotations**
		Periodic Report (LDSS-4310) / **Match Result**	
TALX : ABAWD Eligibility (Income and work hours only)	Yes	Report of work activity under 80 hours per month for able-bodied adult in H/H with no child under 18. / Hours worked per month when calculated are consistent with **LDSS-4310.**	ABAWD work hours are verified. Worker should review work hours and income to see if change is needed in SNAP Employment Status Code and ABAWD indicator code. Question of ABAWD eligibility should be addressed at next recertification. If there is a change in income, budget income, per current procedures, and send notification of action taken on case, as required. If there is a loss of hours and the individual is subject to SNAP work requirements, check that s/he is not subject to a Voluntary Quit sanction.

ADDITIONAL NOTES:
1) TALX – This match provides employment and income verification of employees of companies that register with the TALX corporation – *not all employers report information to TALX.*

Computer Match:	**Child Support Income**		
Eligibility Factor(s)	**Verified Upon Receipt?**	**Comparison of Periodic Report & Match Results**	**Instructions/Annotations**
		Periodic Report (LDSS-4310) / **Match Result**	
Unearned Income, Household Composition	Yes	No change reported in Child Support Income / Income Amount for listed child/children in H/H member(s) in Match is consistent with **LDSS-4310**/Case Information.	Child Support Income for listed child/children in H/H is verified; no document request is needed for the eligibility factor(s). If change in Child Support Income, budget income, per current procedure, and send notification of action taken on case, as required.
		Change reported in Child Support Income for H/H member(s)	
Unearned Income	Yes	No change reported in Child Support Income / Child Support Income Amount for child/children in H/H in Match is More or Less than Income reported on **LDSS-4310** or in Case Information.	Budget income, per current procedure, and send notification of action taken on case, as required.
		Change reported in Child Support Income for H/H member(s)	

LDSS-4310 (Rev. 10/15)

Periodic Report

Supplemental Nutrition Assistance Program (SNAP)

You must fill out this Report and return it to the address listed on the back by _____ to continue getting benefits.

WHEN YOU RETURN THIS REPORT, MAKE SURE THAT THE **LOCAL DISTRICT ADDRESS ON THE BACK** OF THIS REPORT SHOWS IN THE RETURN ENVELOPE WINDOW.

This "Periodic Report" helps us to gather information about any changes you may have had since the last time you were in contact with your eligibility worker. Please make sure to read and follow all the instructions before filling out this "Periodic Report". It is important for you to complete, sign and return this "Periodic Report" by the due date listed above. Failure to do so may result in your Child Care and/or SNAP Benefits being discontinued.

CASE NAME		CASE NUMBER
OFFICE	UNIT	WORKER
If you have any questions on how to fill out this Report, call :**(___)** _____	We must get your completed Report by _____. If we don't get the completed Report by this date, your Child Care and/or SNAP Benefits will stop. Failure to return this report will not affect your Medicaid coverage.	

General Instructions

1. You must **answer all questions** on this Report. Answer all questions on this Report for everyone who is getting, **or** anyone who is legally responsible for someone getting Child Care and/or SNAP Benefits.
2. You must complete and sign this Report and return it to the address on the back of this report by _____, or your Child Care or SNAP Benefits may be reduced or closed.

Reminder: If you are also receiving Temporary Assistance and Medicaid, you must report any changes to your worker within 10 days. For **SNAP,** you must report within ten days after the end of the month if your total monthly gross income exceeds the 130% limit you have been given. **If anyone in your SNAP household is an Able-Bodied Adult Without Dependents** ("ABAWD"), you **MUST** also report if their work hours go below 80 hours a month within 10 days after the end of that month. Otherwise, you do not need to report changes at any time other than on this Periodic Report or at Recertification, whichever occurs first. You must contact your worker immediately if any changes occur that affect your **Child Care**.

LDSS-4310 (Rev. 10/15)

SECTION 1: Please list ALL income for EACH household member. If you are only receiving SNAP benefits, you only have to list earnings here for each household member who works.

(Examples of income include earnings from a job, Unemployment Insurance, Social Security Benefits, Supplemental Security Income [SSI])

Who	Name of Employer or Other Source of Income	How Often? (Daily, Weekly, Bi-Weekly, Monthly)	Total # of Hours Worked Per Week

Send in proof of all income that any household member got during the entire month of _____.

SECTION 2: Have there been any other changes (read boxes below) since your last Report, or do you expect any changes?

No ☐ or Yes ☐ **If Yes, you must check (√) at least one of the boxes below.**

☐ An able-bodied adult in your household did not work/participate in a work activity for at least 80 hours in each month and your SNAP household does not include a child under 18 years of age. (Write who and the months not meeting the requirement below.)

☐ Your household moved (Write the new address below.)

☐ Someone moved into or out of your household (Write who moved and when and new amount of rent.)

☐ Your rent went up or down (Write new rent amount.)

☐ You now pay separately from your rent for: ☐Heating ☐Air Conditioning ☐Other utilities (electricity, cooking gas, water, sewer, trash)

☐ Someone started or left work (Write who, when, and where they started or left work.)

☐ Someone had a change in the amount of their unearned income.

☐ Your child care costs (cost you pay not child care subsidy) are new or changed or child care provider changed (Write new amount and who provides the child care.)

☐ Death or Birth of someone in the household (Write who and when.)

☐ Change in legally obligated child support paid by a member of your household (Write who in your household pays the support.)

☐ Other changes that may affect benefits (Write who, what, and when change occurred and give proof, if possible.)

Write the details of your change(s) here, and if you have proof send it in:

_____

_____

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Temporary Assistance Benefits, SNAP Benefits, Child Care Benefits or closing my case. I am aware that Federal and State Law provide for fine and/or imprisonment of any person who fraudulently attempts to receive, or fraudulently receives Temporary Assistance, Medicaid, Child Care or SNAP Benefits to which the person is not entitled. Information reported on this form may affect my eligibility for Medicaid.

I understand that I must contact my worker to report any changes that occur for my Temporary Assistance and Medicaid case within 10 days.

I understand that I must contact my worker immediately if any changes occur that affects my child care. I also understand that if I use a child care provider who is not licensed or registered, my provider must meet certain requirements in order to be paid.

For my SNAP case, I must report changes on the Periodic Report and at Recertification, whichever occurs first. I may also report changes at any other time. If anyone in my SNAP household is an ABAWD, I must also report if their work hours go below 80 hours a month within 10 days after the end of that month.

IMPORTANT- YOU MUST SIGN AND RETURN THIS FORM. IF YOU CHECKED "YES" TO ANY CHANGES IN SECTION 2, MAKE SURE YOU CHECKED (√) THE BOX(ES) AND GAVE MORE DETAIL. IF THIS REPORT IS NOT COMPLETE, WE WILL SEND YOU A DISCONTINUANCE NOTICE.

Your Signature:	Telephone Number (daytime)

Fill Out & Return In The Envelope Provided

When you return this Report, make sure you can see this address in the return envelope window ➔

INFORME PERIÓDICO

Programa de Asistencia Nutricional Suplementaria (SNAP) es el nuevo nombre del Programa de Cupones para Alimentos.

Debe rellenar este informe y enviarlo a la dirección indicada al reverso, a más tardar, para el _____ para continuar recibiendo beneficios.

CUANDO ENVÍE ESTE INFORME, ASEGÚRESE DE QUE **LA DIRECCIÓN DEL DISTRITO LOCAL IMPRESA AL REVERSO** APAREZCA EN LA VENTANILLA DEL SOBRE DE DEVOLUCIÓN.

Este «Informe Periódico» nos asiste a recopilar información sobre todo cambio que se haya producido en su situación desde la última vez que se comunicó con la persona a cargo de su caso. Asegúrese de leer atentamente y seguir las instrucciones antes de rellenarlo. Es importante que lo rellene, lo firme y lo envíe a más tardar a la fecha de vencimiento indicada anteriormente. De lo contrario, se suspenderán los beneficios que recibe del programa de Asistencia para Niños (CAP), Cuidado de Niños y/o del programa SNAP.

CASO A NOMBRE DE		NÚMERO DEL CASO
OFICINA	UNIDAD	TRABAJADOR(A) DE CASOS
Si tiene preguntas sobre cómo rellenar este informe, sírvase llamar al: (____)_____	Debemos recibir el informe rellenado completamente, a más tardar, para el _____. Si no lo recibimos completamente rellenado para esa fecha, sus beneficios de Asistencia para Niños (CAP), Cuidado de Niños y/o subsidio SNAP se suspenderán. El no devolver este informe no afectará su cobertura de Medicaid.	

Instrucciones generales

1. Debe **responder todas las preguntas** de este informe. Responda todas las preguntas por cada una de las personas que recibe (**o** por cada persona legalmente responsable de alguien que recibe) Asistencia para Niños (CAP), Cuidado de Niños, o subsidio SNAP.
2. **No** firme este informe antes del _____**.** Si lo hace, no se considerará que el informe esté completo.
3. Debe rellenarlo y enviarlo a la dirección indicada al reverso, a más tardar, para el _____, de lo contrario se reducirán o se suspenderán los beneficios que recibe de Asistencia para Niños (CAP), Cuidado de Niños o subsidio SNAP.

Recuerde: si usted también recibe Asistencia Temporal y Medicaid, deberá informar a la persona a cargo de su caso, de todo cambio que se dé en las circunstancias de su hogar dentro de los 10 días de haber ocurrido dicho cambio. Con relación al **subsidio SNAP**, deberá informar dentro de los diez días de finalizado el mes si el total de sus ingresos brutos mensuales supera el límite de 130 % que se le otorgó. De lo contrario, no es necesario que informe cambios en ningún otro momento, solamente en el informe periódico o en la revalidación, lo que ocurra primero. Debe comunicarse inmediatamente con la persona a cargo de su caso si se producen cambios que pudiesen afectar los beneficios que recibe del programa de **Cuidado de Niños.**

SECCIÓN 1: sírvase incluir TODOS los ingresos de CADA integrante de la unidad familiar. Si recibe solamente el subsidio SNAP, sólo tiene que indicar en esta sección el sueldo de cada integrante del grupo familiar que cuenta con un empleo.

(Ejemplos de ingresos: pagos por trabajo realizado, Seguro de Desempleo, beneficios del Seguro Social, Seguridad de Ingreso Suplementario [SSI]).

Quién	Nombre del empleador u otra fuente de ingresos	¿Con qué frecuencia? (Por día, por semana, por quincena, por mes)	Cantidad total de horas trabajadas por semana

Envíe comprobantes de <u>cada</u> ingreso recibido por los integrantes del grupo familiar durante el mes entero de _____

Dado que usted participa en el Programa de Asistencia para Niños (CAP), envíe comprobante de ingresos trabajados, ingresos adicionales y costos por cuidado de menores del _____, _____, _____.

<u>SECCIÓN 2:</u> ¿Ha habido algún otro cambio (lea los casilleros a continuación) desde su último informe, o anticipa algún cambio?

No ☐ Sí ☐ **Si contestó «SÍ», deberá marcar (✓) por lo menos uno de los casilleros a continuación.**

☐ Un adulto habilitado para trabajar integrante de su grupo familiar no trabajó / participó en actividades laborales por un mínimo de 80 horas cada mes y su grupo familiar beneficiario de SNAP no incluye un menor de 18 años. (Escriba el nombre de la persona y los meses en que dichos requisitos no se cumplieron).

☐ Su familia cambió de domicilio (escriba el nuevo domicilio a continuación).

☐ Un integrante se incorporó o se retiró del hogar (incluya el nombre de la persona, la fecha y el nuevo monto del alquiler).

☐ Su alquiler aumentó o disminuyó (incluya el nuevo monto del alquiler).

☐ Un integrante comenzó a trabajar o dejó de hacerlo (incluya quién, cuándo y dónde empezó o dejó de trabajar).

☐ Cambio en la cantidad de ingresos no devengados de un integrante del hogar.

☐ Sus gastos de cuidado de menores (lo que usted paga directamente y no el subsidio) han sido modificados o tiene nuevos gastos; o cambió de proveedor de servicios de cuidado de niños (escriba el nuevo monto y quién suministra el cuidado de niños). ☐ Se modificó su necesidad de cuidado de menores debido a un cambio en su horario de trabajo o por otra razón (explique el cambio).

☐ Un cambio en la contribución o subsidio (incluya el tipo de contribución y nuevo monto).

☐ Hay una mujer embarazada (incluya el nombre y la fecha prevista del nacimiento, si se conoce).

☐ Fallecimiento o nacimiento de un integrante del grupo familiar (incluya el nombre y la fecha).

☐ Cambio en el monto de sustento de menores que paga un integrante de su grupo familiar (incluya el nombre de la persona que paga sustento).

☐ Otros cambios que afecten la habilitación para recibir beneficios (incluya nombre del integrante, tipo de cambio, fecha y comprobante, de tenerlo).

Incluya a continuación los detalles de los cambios reportados y envíe comprobantes, si los tiene:

_____

_____

CERTIFICACIÓN: entiendo que la información proporcionada en este informe puede originar cambios en mis beneficios, incluyendo la reducción en el monto de Asistencia Temporal, subsidio SNAP, Cuidado de Niños y o el cierre de mi caso. Estoy en conocimiento de que las leyes federales y del Estado disponen multas o penas de prisión, o ambas, para toda persona que de forma fraudulenta intente obtener o recibir sin derecho alguno prestaciones de Asistencia Temporal, Medicaid, Cuidado de Niños o subsidio SNAP. Los datos contenidos en este informe pueden afectar mi habilitación para recibir Medicaid.

Tengo conocimiento de que debo informarle a la persona a cargo de mi caso de todo cambio que se produzca con relación a mi caso de Asistencia Temporal y Medicaid dentro de los 10 días de ocurrir el cambio.

Entiendo que debo comunicarme inmediatamente con la persona a cargo de mi caso si se producen cambios que modifiquen mis beneficios de cuidado de niños. También entiendo que si utilizo los servicios de un proveedor de cuidado de menores que no cuente con licencia o no esté inscripto, dicho proveedor deberá cumplir con determinados requisitos para poder recibir pagos.

Con respecto a mi caso de subsidio SNAP, debo informar cambios en el informe periódico y en la revalidación, lo que ocurra primero. También puedo informar cambios en cualquier otro momento.

IMPORTANTE- DEBE FIRMAR Y FECHAR ESTE INFORME <u>NO ANTES DEL</u> _____. SI MARCÓ «SÍ» A LA PREGUNTA SOBRE CAMBIOS EN LA SECCIÓN 2, ASEGÚRESE DE MARCAR (✓) LA CASILLA CORRESPONDIENTE SEGÚN EL CAMBIO Y DE PROPORCIONAR DETALLES. SI ESTE INFORME NO ESTÁ COMPLETO, LE ENVIAREMOS UN AVISO DE SUSPENSIÓN DE BENEFICIOS.

Su firma:	Fecha:	Número telefónico (durante el día):

<u>Rellenar y enviar en el sobre adjunto</u>
Cuando devuelva este informe, verifique que esta dirección quede a la vista en la ventanilla del sobre ➔

LDSS-4310A (Rev. 10/15)

FOLLOW-UP TO THE PERIODIC REPORT

CASE NAME	CASE NUMBER	OFFICE/ UNIT NUMBER

WORKER NUMBER	WORKER NAME (CASELOAD)

If you have any questions on how to fill out this Report, call:	We must get your completed Report by _____. If we don't get the completed Report by this date, your Child Care and/or Supplemental Nutrition Assistance Program (SNAP) Benefits will stop. Failure to return this report will not affect your Medicaid coverage.

General Instructions

1. You must **answer all questions** on this Report. Answer all questions on this Report for everyone who is getting, **or** anyone who is legally responsible for someone getting Child Care, and/or SNAP Benefits.
2. Do **not** sign this Report any sooner than _____**.** If you do, this report is not considered complete.
3. You must complete this Report and return it to the address on the front of the enclosed notice by _____, or your Child Care or SNAP Benefits may be reduced or closed.

Reminder: If you are also receiving Temporary Assistance and Medicaid, you must report any changes to your worker within 10 days. For **SNAP,** you must report within ten days after the end of the month if your total monthly gross income exceeds the 130% limit you have been given. **If anyone in your SNAP household is an Able-Bodied Adult Without Dependents** ("ABAWD"), you **MUST** also report if their work hours go below 80 hours a month within 10 days after the end of that month. Otherwise, you do not need to report changes at any time other than on this Periodic Report or at Recertification, whichever occurs first. You must contact your worker immediately if any changes occur that affect your **Child Care**.

<u>SECTION 1</u>: Please list ALL income for EACH household member. If you are only receiving SNAP benefits, you only have to list earnings here for each household member who works.

(Examples of income include earnings from a job, Unemployment Insurance, Social Security Benefits, Supplemental Security Income [SSI])

Who	Name of Employer or Other Source of Income	How Often? (Daily, Weekly, Bi-Weekly Monthly,)	Total # of Hours Worked Per Week "Report Month"

Send in proof of <u>all</u> income that any household member got during the entire month of

_____. (Report Month)

SECTION 2: Have there been any other changes (read boxes below) since your last Report, or do you expect any changes?

No ☐ or Yes ☐ **If Yes, you must check (√) at least one of the boxes below.**

☐ An able-bodied adult in your household did not work/participate in a work activity for at least 80 hours in each month and your SNAP household does not include a child under 18 years of age. (Write who and the months not meeting the requirement below.)
☐ Your household moved (Write the new address below.)
☐ Someone moved into or out of your household (Write who moved and when and new amount of rent.)
☐ Your rent went up or down (Write new rent amount.)
☐ You now pay separately from your rent for:
☐Heating ☐Air Conditioning ☐Other Utilities (electricity, cooking gas, water, sewer, trash)
☐ Someone started or left work (Write who, when, and where they started or left work.)
☐ Someone had a change in the amount of their unearned income.
☐ Your child care costs (cost you pay not child care subsidy) are new or changed or child care provider changed (Write new amount and who provides the child care.)
☐ Death or Birth of someone in the household (Write who and when.)
☐ Change in legally obligated child support paid by a member of your household (Write who in your household pays the support.)
☐ Other changes that may affect benefits (Write who, what, and when change occurred and give proof, if possible.)

Write the details of your change(s) here, and if you have proof send it in:

_____

_____

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Temporary Assistance Benefits, SNAP Benefits, Child Care Benefits or closing my case. I am aware that Federal and State Law provide for fine and/or imprisonment of any person who fraudulently attempts to receive, or fraudulently receives Temporary Assistance, Medicaid, Child Care or SNAP Benefits to which the person is not entitled. Information reported on this form may affect my eligibility for Medicaid.

I understand that I must contact my worker to report any changes that occur for my Temporary Assistance and Medicaid case within 10 days.

I understand that I must contact my worker immediately if any changes occur that affects my child care. I also understand that if I use a child care provider who is not licensed or registered, my provider must meet certain requirements in order to be paid.

For my SNAP case, I must report changes on the Periodic Report and at Recertification, whichever occurs first. I may also report changes at any other time. If anyone in my SNAP household is an ABAWD, I must also report if their work hours go below 80 hours a month within 10 days after the end of that month.

IMPORTANT- YOU MUST SIGN AND DATE THIS FORM NO SOONER THAN _____. IF YOU CHECKED "YES" TO ANY CHANGES IN SECTION 2, MAKE SURE YOU CHECKED (√) THE BOX(ES) AND GAVE MORE DETAIL. IF THIS REPORT IS NOT COMPLETED, WE WILL SEND YOU A DISCONTINUANCE NOTICE.

Your Signature:	Date:	Telephone Number (daytime)

SEGUIMIENTO AL INFORME PERIÓDICO

CASE NAME	CASE NUMBER	OFFICE/UNIT NUMBER

WORKER NUMBER	WORKER NAME (CASELOAD)

Si tiene preguntas sobre cómo rellenar este informe, marque el:	Debemos recibir este informe rellenado, a más tardar, para el _____. Si no lo recibimos para esa fecha sus beneficios de Cuidado de Niños y/o subsidio SNAP cesarán. El no devolver el presente informe no afectará su cobertura de Medicaid.

Instrucciones generales

1. Debe **contestar todas las preguntas** de este informe. Hágalo por cada beneficiario (**o** por cada persona legalmente responsable de un beneficiario) de Cuidado de Niños y/o subsidio SNAP.
2. **No** firme este informe antes del _____. Si lo hace, este informe no se considerará completo.
3. Debe rellenarlo y devolverlo a la dirección que figura en el anverso de la notificación adjunta a más tardar para el _____, o sus beneficios de Cuidado de Niños y/o subsidio SNAP se reducirán o se suspenderán.

Recordatorio: si también recibe Asistencia Temporal y Medicaid, debe informar todo cambio en las circunstancias de su grupo familiar a la persona a cargo de su caso dentro de los 10 días de ocurrido dicho cambio. En cuanto al subsidio **SNAP,** debe reportar, dentro de los 10 días posteriores al fin de mes, si sus ingresos mensuales brutos totales exceden el límite del 130 % que se le impuso. Fuera de esos casos, no es necesario que informe ningún otro cambio, solamente en este informe o en su revalidación, lo que ocurra primero. Debe comunicarle a la persona a cargo de su caso de todo cambio que se dé que pueda afectar el subsidio que recibe del programa de **Cuidado de Niños.**

SECCIÓN 1: favor de hacer una lista de TODOS los ingresos de CADA miembro de su grupo familiar. Si usted solamente recibe el subsidio SNAP, liste el salario solamente de los integrantes del grupo familiar que trabajan.

(Ejemplos de ingresos: pagos por trabajo realizado, Seguro de Desempleo, Seguro Social, Seguridad de Ingreso Suplementario [SSI]).

Quién	Nombre del empleador u otra fuente de ingresos	¿Con qué frecuencia? (por día, por semana, cada dos semanas, por mes).	Número total de horas trabajadas por semana «Mes reportado»

Proporcione comprobantes de todos los ingresos recibidos por los miembros del grupo familiar durante el mes entero de _____. (Report Month)

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SECCIÓN 2: ¿Ha ocurrido algún otro cambio (lea los casilleros más abajo) desde su último informe o prevé usted que ocurra algún cambio?

No ☐ ó Sí ☐ **Si contestó «Sí», debe marcar (✓) por lo menos uno de los siguientes casilleros:**

☐ Un adulto habilitado para trabajar integrante de su grupo familiar no trabajó / participó en actividades laborales por un mínimo de 80 horas cada mes y su grupo familiar beneficiario de SNAP no incluye un menor de 18 años. (Escriba el nombre de la persona y los meses en que dichos requisitos no se cumplieron).
☐ Su familia cambió de domicilio (escriba el nuevo domicilio a continuación).
☐ Un integrante se incorporó o se retiró del hogar (incluya el nombre de la persona, la fecha y el nuevo monto del alquiler).
☐ Su alquiler aumentó o disminuyó (incluya el nuevo monto del alquiler).
☐ Paga ahora por separado del alquiler por gastos de: ☐ Calefacción ☐ Aire acondicionado ☐ Otros servicios públicos (electricidad, gas para cocinar, agua, aguas negras, recolección de basura).
☐ Un integrante comenzó a trabajar o dejó de hacerlo (incluya quién, cuándo y dónde empezó o dejó de trabajar).
☐ Cambio en la cantidad de ingresos no devengados de un integrante del grupo familiar.
☐ Sus gastos de cuidado de menores (lo que usted paga directamente y no el subsidio) han sido modificados o tiene nuevos gastos; o cambió de proveedor de servicios de cuidado de niños (escriba el nuevo monto y quién suministra el cuidado de niños).
☐ Fallecimiento o nacimiento de un integrante del hogar (incluya el nombre y la fecha).
☐ Cambio en el monto de sustento de menores por orden judicial que paga un integrante de su hogar (incluya el nombre de la persona que paga sustento).
☐ Otros cambios que afecten la habilitación para recibir beneficios (incluya nombre del integrante, tipo de cambio, fecha y comprobante, de tenerlo).

Escriba aquí los detalles de los cambios y, si tiene comprobantes, proporciónelos:

_____

_____

CERTIFICACIÓN: entiendo que la información proporcionada en este informe puede originar cambios en mis prestaciones, incluyendo la reducción en el monto de Asistencia Temporal, subsidio SNAP, Cuidado de Niños o el cierre de mi caso. Es de mi pleno conocimiento que las leyes federales y del Estado, disponen multas o penas de prisión, o ambas, a toda persona que de forma fraudulenta intente obtener o recibir sin derecho alguno prestaciones de Asistencia Temporal, Medicaid, Cuidado de Niños o subsidio SNAP. Los datos en este informe pueden afectar mi habilitación para recibir Medicaid.

Tengo conocimiento de que debo informarle a la persona a cargo de mi caso de todo cambio que se produzca con relación a mi caso de Asistencia Temporal y Medicaid dentro de los 10 días de ocurrir dicho cambio.

Entiendo que debo comunicarme inmediatamente con la persona a cargo de mi caso si se producen cambios que modifiquen mi subsidio de cuidado de niños. También entiendo que si utilizo los servicios de un proveedor de cuidado de menores que no cuente con licencia o no esté inscripto, dicho proveedor deberá cumplir con ciertos requisitos para poder recibir pagos a cambio de dicho servicio.

Con respecto a mi caso de subsidio SNAP, debo informar cambios en el informe periódico y en la revalidación, lo que ocurra primero. También puedo informar cambios en cualquier otro momento.

IMPORTANTE: DEBE FIRMAR Y FECHAR ESTE FORMULARIO NO ANTES DEL _____. SI RESPONDIÓ «SÍ» A LOS CAMBIOS SEÑALADOS EN LA SECCIÓN 2, ASEGÚRESE DE HABER MARCADO (✓) LOS CASILLEROS Y DE PROPORCIONAR MÁS DETALLES. SI ESTE INFORME NO SE RELLENA, LE ENVIAREMOS UN AVISO DE SUSPENSIÓN DE PRESTACIONES.

Su firma:	Fecha:	Número de teléfono (durante el día)