

**North Carolina Division of Social Services  
Food and Nutrition Services (FNS) Notice of Expiration Recertification Form**

Co. #	Worker Name	Worker #	Case #	Product Delivery #	Date Mailed

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 \_\_\_\_\_.

(DSS Address)

(Household Address)

**What Do I Need To Do With This Form?**

You or your authorized representative must entirely complete this 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, or fax to us at the above address. 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.

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 Department of Social Services 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 \_\_\_\_\_.

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 USCIS to check the immigration status on the household members who give us their immigrant documents. If an applicant does not provide this information, they will be ineligible for benefits. By signing this form 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.

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.

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Residence address (if different from mailing)  
\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Telephone Company Provider \_\_\_\_\_ Language you speak \_\_\_\_\_

Your Signature or Authorized Representative \_\_\_\_\_ Date Signed \_\_\_\_\_

PROVIDE PROOF OF ANY NEW OR CHANGED BILLS SINCE YOUR LAST RECERTIFICATION

1. How much do you pay for rent where you live? \$ \_\_\_\_\_ How often paid? \_\_\_\_\_  
 Circle any that you receive: HUD Section 8 Public Housing What is your portion of the rent? \_\_\_\_\_  
 How much do you pay for lot rent where you live? \$ \_\_\_\_\_ How often paid? \_\_\_\_\_
2. How much do you pay for your home mortgage? \$ \_\_\_\_\_ How often paid? \_\_\_\_\_  
 Property Taxes: (if paid separately) Amount paid? \$ \_\_\_\_\_ How often paid? \_\_\_\_\_  
 Homeowners Insurance: (if paid separately) Amount paid? \$ \_\_\_\_\_ How often? \_\_\_\_\_  
 Homeowners Dues: (if paid separately) \$ \_\_\_\_\_ How often? \_\_\_\_\_
3. What utility bills are you responsible for paying (if paid separate from your rent)? (Check all that apply).  
 Heat  Kerosene  Water/Sewage  Electricity  Coal  LP Gas  
 Telephone/Cell Phone  Fuel Oil  Garbage/Trash  Wood  
 Natural Gas  Utility Excess (Public Housing)  
 How do you heat your home? \_\_\_\_\_ How do you cool your home? \_\_\_\_\_
4. Does anyone help pay your bills?  Yes  No If yes, who helps? \_\_\_\_\_
5. Did you get a Low Income Energy Assistance Program (LIEAP) check at your current residence within the past 12 months?  Yes  No \_\_\_\_\_
6. Is your household responsible for paying any child or disabled adult care?  Yes  No  
 Who receives the care? \_\_\_\_\_  
 Who pays? Amount per month or parent fee \$ \_\_\_\_\_  
 Name and phone number of care provider/babysitter \_\_\_\_\_  
 Child/adult care transportation expenses \$ \_\_\_\_\_
7. Does any person 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.  Yes  No If yes, do you wish to claim a deduction for these expenses?  
 Yes  No To get this deduction you must attach receipts or a computer printout of your expenses.
8. Does your household pay court ordered child support for children outside your home (include court ordered health insurance payments)?  Yes  No Who pays child support? \_\_\_\_\_  
 Who is it paid to? \_\_\_\_\_ Child's Name? \_\_\_\_\_ Amount you pay \$ \_\_\_\_\_ How often? \_\_\_\_\_
9. List everyone who lives with you below. (Attach another sheet if needed)

Name (First, Middle Initial, & Last)	Relation to You	Birth Date	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 Hispanic (Yes/No)	*Optional Race (see below)	Buy & Cook Together? (Yes/No)
	Self									

\* Social Security Numbers and Citizenship information are not needed for those not applying for benefits.

\*Benefits 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 5- White

\*\*These questions may assist in identifying Able-Bodied Adults without Dependents (ABAWD)

**\*\*10.** Does anyone in your household work?  Yes  No If yes, complete below. Is anyone in your household getting ready to start a job?  Yes  No If yes, enter expected start date and complete below \_\_\_\_\_.

Name of person \_\_\_\_\_ Employer \_\_\_\_\_ How often paid? \_\_\_\_\_

Name of person \_\_\_\_\_ Employer \_\_\_\_\_ How often paid? \_\_\_\_\_

Attach all income verification for 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 years 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 you do not have all your check stubs, you may have your employer complete and sign the section below.

A- Employer Name:						B- Employer Name:							
Employer Phone#:						Employer Phone#:							
How often paid?						How often paid?							
	Date Pay Received			Gross Pay	Tips	Total Hours		Date Pay Received			Gross Pay	Tips	Total Hours
	Mo	Day	Yr					Mo	Day	Yr			
1							1						
2							2						
3							3						
4							4						
5							5						
EMPLOYER SIGNATURE						EMPLOYER SIGNATURE							
DATE						DATE							

**11.** Does anyone in your household get money other than from work? Examples: Cash, Contributions, Work First, Child Support, \*\*Unemployment Benefits, \*\*Social Security, \*\*SSI, \*\*Worker's Compensation, \*\*VA, etc.  Yes  No If yes, attach verification for the month listed on Page 1. Please enter the information in the chart below. If you receive Cash, Contributions, or Child Support, attach verification for the month listed on Page 1. (Attach another sheet if needed)

Type of Money	Who Gets the Money?	Who Gives the Money?	Phone Number and Address of person who gives you money	How Much?	How Often?

**\*\*12.** Does anyone work as a volunteer or participate in a work training program?  Yes  No

Name	Name of Volunteer Site or Work Training Program	Site address and phone number if available	Start Date	End Date	Hours per Week

**13.** Check yes or no to assets listed below that you own, someone else in your household owns, or jointly own with a non- household member. We will determine if verification is needed and if it is accessible to you. (Attach another sheet if needed)

Type of Asset	Yes	No	Balance Or Value	Who Owns It?	Where do you keep this asset and what is the account number?
Cash on Hand					
Checking Account					
Savings Account					
Other					

Does anyone in your household fit a situation below? IF YES Who?

- \*\*14. Do you know of anything that has changed in your household such as anyone stopping or starting work or school within the last 6 months?  Yes  No If yes, please list the changes \_\_\_\_\_  
If someone stopped working who? \_\_\_\_\_ Total hours worked in past 30 days? \_\_\_\_\_
  - 15. Is anyone in your household age 16 or older and attending school at least half time?  Yes  No If yes, list persons name and school they attend \_\_\_\_\_
  - 16. Does anyone in your household have a felony drug conviction or controlled substance after August 22, 1996?  Yes  No If yes, please tell us his/her name, date, type, and place of conviction: \_\_\_\_\_
  - 17. Is anyone in your household in violation of probation or parole or running from the law to avoid felony prosecution?  Yes  No If yes, please tell us his/her name and the date and type of violation \_\_\_\_\_
  - 18. Have you or any member of your household been convicted of trading benefits for drugs after August 22, 1996?  Yes  No If yes, please tell us his/her name, date, type, and place of conviction \_\_\_\_\_
  - 19. Have you or any member of your household been convicted of buying or selling benefits \$500 or more after August 22, 1996?  Yes  No If yes, please tell us his/her name, and date \_\_\_\_\_
  - 20. Have you or any member of your household been convicted of fraudulently receiving duplicate benefits in any State after August 22, 1996?  Yes  No If yes, please tell us his/her name, date, type, and place of conviction \_\_\_\_\_
  - 21. Have you or any member of your household been convicted of trading benefits for guns, ammunitions, or explosives after August 22, 1996?  Yes  No If yes, please tell us his/her name, date, type, and place of conviction \_\_\_\_\_
  - \*\*22. Is anyone in your household physically or mentally unfit for employment?  Yes  No \_\_\_\_\_
  - \*\*23. Does anyone operate a Home School at least 30 hours a week?  Yes  No \_\_\_\_\_
  - \*\*24. Does anyone care for an incapacitated person (does not have to live in the home)?  Yes  No \_\_\_\_\_
  - \*\*25. Does anyone participate in an official Refugee Employment Program?  Yes  No \_\_\_\_\_
  - \*\*26. Is anyone in the household unable to work due to alcohol and/or drug addiction?  Yes  No \_\_\_\_\_
  - \*\*27. Is anyone in the household pregnant?  Yes  No \_\_\_\_\_
- 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 there is an authorized representative listed on page 1 do you want them to continue?  Yes  No

**How to Get A Fair Hearing**

You have the right to ask for a hearing 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.

**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 Department of Social Services 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 first offense, two years for second offense, and permanently for third offense. 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 be not be eligible for benefits for two years for the first offense, and permanently for the second offense. 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 may give up my right to receive a deduction for these expense(s)**

Your Signature: _____	Date Signed: _____
Authorized Representative or Witness Signature (if applicable) _____	Date Signed: _____
Your Telephone Number: _____ Check which applies <input type="checkbox"/> Home <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work <input type="checkbox"/> Message Number	

\*\*\*AGENCY USE ONLY\*\*\*

Date of Interview _____	<input type="checkbox"/> Telephone <input type="checkbox"/> Office Visit
-------------------------	--

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