LDSS-4310A (Rev. 1/13)

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 Assistance (CAP), 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 Assistance (CAP), 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 Assistance (CAP), 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. 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)

Child Assistance Program (CAP) cases must send in proof of earnings, other income, and child care costs for the months of _____, _____, and _____. (Report Quarter)

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.)
☐ 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.)
☐ Someone is pregnant (Write who and expected delivery date, if known.)
☐ 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.

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)