RESET FIELDS

SEMIANNUAL REPORTING FORM
READ FORM & INSTRUCTIONS CAREFULLY

CASE IDENTIFICATION						
CO	RECORD	CASH	MA	FS	DIST	CSLD

This signed and completed form along with the required proof must be in the county assistance office by:

REPORTING FOR

DPW USE ONLY			
COMPLETE ☐	DATE		
INCOMPLETE			
☐ 1	☐ 2	☐ 2V	☐ 3V
☐ 4	☐ 4V	☐ 5	☐ 5V
☐ 8	☐ 8V		
☐ ALL			
☐ UNSIGNED			
AUTHORIZED			
WORKER			
CLERICAL			

Si necesita formulario en español, communiquese con su trabajador immediatamente, tiene que completar, firmar y devolver esta forma la “county assistance office” para la fecha de vencimiento que se indica o su caso será cerrado, incluyendo su assistencia médica, y/o sus cupones de comida (7 CFR 273.12 (a)(1)(vii) and 55 PA Code 133.23 (a)(1)(viii), 133.84(d), 140.401, 140.513(3), 201.1, 201.3).

We must review your eligibility so you may continue to receive benefits.

YOU MUST:

- **Review and answer the questions on this form (if you need additional space for any of the questions, use a separate piece of paper and attach it to this form).**
- **Sign the certification section. An unsigned form is considered incomplete.**
- **Mail completed form in the return envelope provided or fax the form to the county assistance office with:**
  - **Proof of all household members’ income from work.**
  - **Proof of any changes reported on this form.**

Please read the instructions on page A and if you need help or if you have questions about the proof needed to verify changes, call your caseworker or change center.

Please return all pages of this form in the enclosed envelope.

If you wish to claim good cause, sign and include page A.

For Voter Registration information, see page C.

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1. These are the household members you last reported to be in your household.

	Last Name	First Name	M.I.	Date of Birth

Did anyone move into or out of your household? ☐ Yes ☐ No If yes, list who and their relationship to you.

2. These are the household members you last reported to be working and where they worked.

	First Name	Where Employed	Date Employment Began

Did any household member start a new job, change a job, or stop working? ☐ Yes ☐ No If yes, list any changes, such as job start date, end date, date of first pay, how often paid.) Provide proof (pay stubs, employer statements, etc.)

3. Provide proof (pay stubs, employer statements, etc.) of all work income any household member received in the month of

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4. These are the household members you last reported to have income from a source other than work or public assistance (Examples: child support, Social Security, pension income, etc.)

	First Name	Type of Income	Amount

Did any household member lose or start receiving income or have a change in amount? ☐ Yes ☐ No If yes, list any changes. Provide proof (award letter, support court orders, etc.)

5. Is the address on this form your current address? ☐ Yes ☐ No For voter registration information see page C. If no, what is your new address? Provide proof (Examples: lease, landlord statement, deed, etc.)

If you receive food stamps and you have moved, what are your shelter (rent/mortgage) and utility costs? Do you pay for your own heating and/or air conditioning? ☐ Yes ☐ No
*Answering these questions may help you receive more food stamp benefits.

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6.	This is the last reported amount of child support paid for children outside the household.	
	Did any household member have a change in the amount he is requested to pay? ☐ Yes ☐ No If yes, list any changes. Provide copy of support court order or letter and proof of payment. *You do not have to answer this question or provide proof. Answering this question and providing proof may help you to remain eligible or receive more benefits.	

7.	This is the information you last reported about child care or for care of a sick or disabled person.		
	Caregiver	Paid For	Amount
	Are there any changes? ☐ Yes ☐ No If yes, list any changes. Provide copy of bill or statement from caregiver. * You do not have to answer this question or provide proof. Answering this question and providing proof may help you to remain eligible or receive more benefits.		

8.	These are the household members you last reported to have resources, including vehicles. (Examples: bank accounts, property, etc.) * If this form is to determine eligibility for medical benefits only and you are pregnant OR under 21 years of age OR living with your dependent child who is under the age of 21, you do not have to answer this question.				
	First Name	Resource Type	Total Value	Amount Owed	Resource Description

Continued on next page...

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	First Name	Resource Type	Total Value	Amount Owed	Resource Description

Has the information in this section changed? ☐ Yes ☐ No
Does any household member have resources not listed above? ☐ Yes ☐ No
If you answered yes to either question, list any changes. Provide proof (Copy of bank statement, vehicle registration, etc.)

CERTIFICATION

I swear that the information given on this form is complete and correct to the best of my knowledge. I agree to report any changes in circumstances that may affect my eligibility or the amount of cash, Medicaid and/or food stamp benefits. I understand that willful failure to give accurate information or to report changes may result in a fine or imprisonment or both. I understand that changes in income, circumstances, and/or other factors as reported on this form may cause my cash assistance, medicaid and/or food stamp benefits to be increased, decreased or stopped.

_____ or _____ _____

Signature of Payment Name | Authorized Representative for Food Stamps | Date

Daytime Telephone Number

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INSTRUCTIONS

Your household circumstances require you to report semiannually (every 6 months). The information on the semiannual reporting form is needed to determine your continued eligibility for cash, food stamps, Extended Medical Coverage and/or Medicaid. It is also needed to calculate the amount of your monthly cash and/or food stamp benefits. You must give us information for the reporting month shown on page 1 of the form. You are asked to provide child care information: failure to do so could lead to lower benefits or ineligibility.

Note: You may report changes at any time if the change would increase your benefits (such as if you lose your job or your hours of work decrease).

When answering the questions, you must give us information for all persons included in your cash, food stamps and/or Medicaid benefits. This includes stepparents and information for sponsors of aliens, even if the sponsor does not live in your home. You can use a separate sheet of paper to explain any of your answers or give additional information. A separate sheet of paper must be sent in with the form.

You must complete, sign and return the form to the county assistance office by the date shown on page 1 of the form. IF YOU NEED HELP TO COMPLETE THE FORM, CALL YOUR CASEWORKER OR CHANGE CENTER.

NOTICE

- If the form is late or incomplete, you may not receive your cash and/or food stamp benefits on time.
- If you DO NOT return the form, action may be taken to close your case. This action may include your cash assistance, food stamps, child care payments, and/or Medicaid (55 Pa code 133.84(d), 104.401, 140.513(3), 201.1, 201.3, 7 CFR 273.12 (a)(1)(viii) and 273.7(d)(4)(i)).
- If you disagree with the decision to reduce or stop your benefit(s), you have the right to appeal. You will be sent a notice to tell you about any proposed reduction or stoppage of your benefits.
- If your case is closed, you may have to complete a new application and be otherwise eligible to have benefits restored.

NOTICE

YOU MAY CLAIM “GOOD CAUSE” if you have good reason for not completing the form or returning it late. To claim “good cause”, you must state your reason(s) in the space below, sign your statement and return this form to the county assistance office as soon as possible, within 30 days from the due date. You may also claim “good cause” orally by contacting your caseworker, but you must also return this form to the county assistance office as soon as possible, within 30 days from the due date.

I AM CLAIMING “GOOD CAUSE” BECAUSE:
CLIENT SIGNATURE:
For DPW use ONLY Approved _____ Disapproved _____

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IMPORTANT INFORMATION

About the Department of Public Welfare's Notice of Privacy Practices
If you need a free translation of this information, contact your county assistance office.

(Taglines forthcoming...)

YOU MAY REQUEST A COPY OF THE DEPARTMENT'S NOTICE OF PRIVACY PRACTICES

The Department of Public Welfare's Notice of Privacy Practices explains how information about you is used and disclosed. This notice is available at any time through your county assistance office and online at www.dpw.state.pa.us. If you would like us to send you a copy of the Notice of Privacy Practices, please contact your caseworker. You may also request a copy in person at your county assistance office.

USTED PUEDE SOLICITAR UNA COPIA DEL AVISO DE LAS NORMAS DE PRIVACIDAD DEL DEPARTAMENTO

El Aviso de las Normas de Privacidad del Departamento de Bienestar publico explica como se utiliza y divulga información sobre usted. El Aviso esta disponible en cualquier momento en la Oficina de Asistencia del Condado o en linea en www.dpw.state.pa.us. Si desea que nosotros le enviemos una copia del Aviso de las Normas de Privacidad, comuníquese con su asistenete social. Tambíen puede solicitar una copia un persona en También puede solicitar una copia un persona en la Oficina de Asistencia del Condado.

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Voter Registration (Optional)

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.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to client ___/___/_____ ☐ Sent to voter registration ___/___/_____ ☐ Mailed to client ___/___/_____

☐ Declined, not interested ___/___/_____ ☐ Not a U.S. citizen ___/___/_____ ☐ Declined, already registered ___/___/_____

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