

**SEMIANNUAL REPORTING  
FORM  
READ FORM & INSTRUCTIONS  
CAREFULLY**

CASE IDENTIFICATION						
CO	RECORD	CASH	MA	SNAP	DIST	CSLD

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

**REPORTING FOR**

Si necesita un formulario en español, comuníquese con su trabajador inmediatamente. Tiene que completar, firmar y devolver esta forma a la "county assistance office" para la fecha de vencimiento que se indica o su caso será cerrado, incluyendo su asistencia médica, y/o su SNAP (7 CFR 273.12 (a)(1)(vii) y 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).**
- **PLEASE USE BLUE OR BLACK INK ONLY TO COMPLETE 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 the Customer Service 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.

DHS USE ONLY			
COMPLETE	DATE		
<input type="checkbox"/>			
INCOMPLETE			
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 2V	<input type="checkbox"/> 3V
<input type="checkbox"/> 4	<input type="checkbox"/> 4V	<input type="checkbox"/> 5	<input type="checkbox"/> 5V
<input type="checkbox"/> 8	<input type="checkbox"/> 8V		
<input type="checkbox"/> ALL			
<input type="checkbox"/> UNSIGNED			
AUTHORIZED			
WORKER			
CLERICAL			

CASE IDENTIFICATION						
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GOOD	BAD		
<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Please use blue or black ink only to complete this form.

Please darken the complete circle "Yes" or "No" as your response.

TELL US ABOUT PEOPLE IN YOUR HOUSEHOLD		Yes	No
1. Did anyone move into or out of your household?		<input type="radio"/> Y	<input type="radio"/> N

These are the household members you last reported to be in your household.	
Name (last, first, middle initial)	Date of Birth

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If you answered yes to Question #1 about people in your household, list who and their relationship to you in the space below.


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<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

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Please darken the complete circle "Yes" or "No" as your response.

INCOME FROM WORK		Yes	No
2. Did any household member start a new job, change a job, or stop working?		<input checked="" type="radio"/> Y	<input type="radio"/> N

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

First Name	Where Employed	Date Employment Began

If you answered yes to Question #2 about work income, list any changes, such as job start date, end date, date of first pay, how often paid in the space below. Provide proof (pay stubs, employer statements, etc.).

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

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<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

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INCOME FROM OTHER SOURCES		Yes	No
4. Did any household member lose or start receiving income or have a change in amount?		<input type="radio"/> Y	<input type="radio"/> N

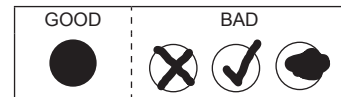
**These are the household members you last reported as having income from a source other than work or public assistance. (Examples: child support, Social Security, pension income, etc.)**

First Name	Type of Income	Amount

**If you answered yes to Question #4 about income from other sources, list any changes. Provide proof (award letter, support court orders, etc.).**

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SHELTER AND UTILITIES		For voter registration information see page C	Yes	No
5. Is the address on this form your current address?		➔	<input checked="" type="radio"/> Y	<input type="radio"/> N

If you answered no to Question #5 about your current address, what is your new address? Provide proof (Examples: lease, landlord statement, deed, etc.).

ANSWER ONLY IF YOU RECEIVE SNAP BENEFITS AND HAVE MOVED		Answering these questions may help you receive more SNAP benefits.		Yes	No
Do you pay for your own heating and/or air conditioning?		➔	<input checked="" type="radio"/> Y	<input type="radio"/> N	

Answer only if you receive SNAP benefits and have moved.  
What are your shelter (rent/mortgage) and utility costs?

CHILD SUPPORT	Yes	No
6. Did any household member have a change in the amount he/she is requested to pay?	<input checked="" type="radio"/> Y	<input type="radio"/> N

This is the last reported amount of child support paid for children outside the household.

If you answered yes to Question #6 about child support payments, list any changes. Provide copy of support order or letter and proof of payment.

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<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Please use blue or black ink only to complete this form.

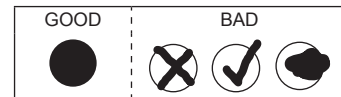
Please darken the complete circle "Yes" or "No" as your response.

CHILD OR DEPENDENT CARE	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.	Yes	No
7. Are there any changes to the information listed below?		<input checked="" type="radio"/> Y	<input type="radio"/> N

This is the information you last reported about child care or for care of a sick or disabled person.		
Caregiver	Paid For	Amount

If you answered yes to Question #7 about child and dependent care, list any changes. Provide copy of bill or statement from caregiver.

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Please darken the complete circle "Yes" or "No" as your response.

RESOURCES			Yes	No
If this form is to determine eligibility for medical benefits only and you are pregnant OR under 21 years OR living with your dependent child who is under the age of 21, you do not have to answer this question.				
8. Have there been any changes to the resource information listed below?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does any household member have resources not listed below?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These are the household members you last reported as having resources including vehicles (Examples: bank account, property, etc.).				
Owner	Resource Type	Resource Description	Total Value	Amount Owed

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<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Please use blue or black ink only to complete this form.

Please darken the complete circle "Yes" or "No" as your response.

**If you answered yes to either question about resource, 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 SNAP 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 SNAP benefits to be increased, decreased, or stopped.

\_\_\_\_\_  
Signature of Payment Name

\_\_\_\_\_  
Authorized Representative for SNAP

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Telephone Number



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### INSTRUCTIONS

Your household circumstances require you to report semiannually (every 6 months). The information on the semi-annual reporting form is needed to determine your continued eligibility for cash, the Supplemental Nutrition Assistance Program (SNAP), Extended Medical Coverage and/or Medicaid. It is also needed to calculate the amount of your monthly cash and/or SNAP 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, SNAP 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.

**PLEASE USE BLUE OR BLACK INK AND COMPLETELY FILL IN THE CORRECT CIRCLE WITH YOUR RESPONSE AS DEMONSTRATED ON EACH PAGE OF THIS FORM. FOLLOWING THESE DIRECTIONS WILL ENSURE THAT YOUR FORM IS PROCESSED IN A TIMELY MANNER.**

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 SNAP 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, SNAP, 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.

### GOOD CAUSE

YOU MAY CLAIM "GOOD CAUSE" if you have a good reason for not completing the form or for 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 DHS USE ONLY:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_

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Please return this page if you wish to register to vote.

VOTER REGISTRATION		Yes	No
If you are not registered to vote where you live now, would you like to apply to register to vote here today?		<input type="radio"/>	<input type="radio"/>
<p><b>IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.</b></p>			
<p><b>To register, you must:</b></p> <ol style="list-style-type: none"> <li>1) Be at least 18 on the date of the next election.</li> <li>2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION.</li> <li>3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.</li> </ol>			
<p><b>Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.</b></p> <p>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 Central Unit 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.)</p>			

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE	
<input type="checkbox"/> Given to client ____ / ____ / ____	<input type="checkbox"/> Declined / Not Interested ____ / ____ / ____
<input type="checkbox"/> Sent to Voter Registration ____ / ____ / ____	<input type="checkbox"/> Not a U.S. Citizen ____ / ____ / ____
<input type="checkbox"/> Mailed to Client ____ / ____ / ____	<input type="checkbox"/> Declined, already registered ____ / ____ / ____

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