Department of Children and Family Services
Application for Continued Assistance

RETURN THIS PAGE TO YOUR LOCAL DCFS PARISH OFFICE

Caseload # _____
Redet Month: _____
Case ID: _____
I am reapplying for: _____

I would also like to apply for (check all that apply):
☐ SNAP ☐ FITAP ☐ KCSP

A. Tell Us About You

This information is requested solely for the purpose of determining DCFS compliance with Federal civil rights laws. Your response will not affect consideration of your application and may be protected by the Privacy Act. The information is being collected to assure that program benefits are distributed without regard to race, color, or national origin.

Do you need a new Louisiana Purchase Card? ☐ Yes ☐ No

Can you read and understand English? (¿Puede leer y comprender el inglés?) ☐ Yes ☐ No

If no, what language can you read and understand? (Si no, ¿qué idioma puede leer y comprender?)

First Name	Middle Initial	Last Name	Maiden or Other Name	
Mailing Address	Apt/Lot No.	City	State	Zip Code
Home Address (If different from mailing)	Apt/Lot No.	City	State	Zip Code
( ) Home Telephone Number	( ) Cell Telephone Number		( ) Work or Other Telephone Number	
Social Security Number			Parish of Residence	
Date of Birth	E-mail Address			

Sex: ☐ Male ☐ Female **Ethnicity:** Hispanic/Latino? ☐ Yes ☐ No

Highest grade level completed in school? _____

Marital Status:
☐ Married
☐ Separated
☐ Divorced
☐ Never Married
☐ Widowed

Racial Heritage (check all that apply):
☐ Asian
☐ White
☐ Native Hawaiian/ Pacific Islander
☐ American Indian/ Alaskan Native
☐ Black or African American

Student? ☐ Yes ☐ No
U.S. Citizen? ☐ Yes ☐ No
If no, do you have Immigration papers? ☐ Yes ☐ No
Date of entry in U.S.: _____

B. Tell Us If You Have An Authorized Representative

An Authorized Representative is someone you allow us to talk with about your SNAP benefits. You can name someone, but it is not required.

Would you like to have an Authorized Representative? ☐ Yes ☐ No

If yes, tell us about your Authorized Representative.

Name of Authorized Representative	Relationship to Applicant	( ) Telephone Number	
Address	City	State	Zip Code

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Is an EBT card needed? ☐ Yes ☐ No
Is there an authorized representative? ☐ Yes ☐ No
Identity verified by: ☐ Driver's License ☐ Identification card ☐ Other
Residency verified by:
Marital status verified by:
If applying for FITAP or KCSP, has FITAP/KCSP explained? ☐ Yes ☐ No
Client selected: ☐ FITAP ☐ KCSP

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C. Tell Us About The Other People In Your Household – Do Not Include Yourself

List everyone else who lives in your household, even if you are not applying for them. *This information is requested solely for the purpose of determining DCFS compliance with Federal civil rights laws. Your response will not affect consideration of your application and may be protected by the Privacy Act. The information is being collected to assure that program benefits are distributed without regard to race, color, or national origin.*

Don't miss out on No Cost Health Insurance. If you answer the question below, we will share what you entered on this application with the Louisiana Department of Health (LDH). LDH will sign up anyone who qualifies and send you a letter with more information about the Medicaid program. Children and adults (under age 65 without Medicare) may qualify.

PLEASE ANSWER THE QUESTION BELOW.

☐ Yes, please share my information with LDH so I do not need to complete another application.

☐ No, please do not share my information. Do not help me get Medicaid.

Household Members (Enter Name)	Relation to you (NR=Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	ED Level *	Marital Status	Race/ Ethnic Code **
Last First MI	Complete these sections only for those who need benefits							

**Race: (You may select more than one race)	**Ethnicity:
AN = Alaskan Native **WH** = White **BL** = Black or African American	**Y** = Hispanic or Latino
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander ***ED Level:** List highest grade completed or GED/college	**N** = Not Hispanic or Latino

If you need more space for additional household members, you can write the information on plain paper or ask for an "Additional Household Members Form."

If anyone for whom you are applying is not a U. S. citizen, your worker will complete an Alien Addendum and Checklist with you during your interview for those for whom you are applying.

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Household composition: _____ person household

Are all members linked on LAMI? ☐ Yes ☐ No

Enumeration verified by:

Age and relationship verified by:

Document CR 5

Citizenship: Are all household members U.S. citizens? ☐ Yes ☐ No

If no, complete Alien Addendum and Alien Checklist for all aliens who the household is applying for benefits.

Names of aliens who have opted out of applying for benefits due to immigration status.

RETURN THIS PAGE TO YOUR LOCAL DCFS PARISH OFFICE

D. Tell Us About Your Household	For Office Use Only
Please answer the following questions for yourself and everyone else in your home.	
1. Are you or anyone in your household a fleeing felon? ☐ Yes ☐ No	
2. Are you or anyone in your household in violation of their probation or parole? ☐ Yes ☐ No	
3. Have you or anyone in your household been convicted as an adult for a felony that occurred after February 7, 2014, for one of the following crimes? ☐ Yes ☐ No Aggravated sexual abuse under section 2241 of title 18, U.S.C.; Murder under section 1111 of title 18, U.S.C.; Sexual exploitation and other abuse of children under chapter 110 of title 18, U.S.C.; A Federal or State offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); An offense under State law determined by the Attorney General to be substantially similar to an offense listed above. If yes, who? _____ Is this person in compliance with terms of their sentence? ☐ Yes ☐ No	
4. Have you or anyone in your household been disqualified or had their benefits reduced or stopped for breaking the rules of SNAP, FITAP, KCSP, or SSI? ☐ Yes ☐ No	4. If yes, complete supplement
5. Do you or anyone in your household have a disability? ☐ Yes ☐ No	5. If yes, complete supplement.
6. Does anyone in your household attend high school, college, vocational or technical school? ☐ Yes ☐ No If **yes**, complete the following for each student:	6. If yes, is anyone attending an institution of higher education? ☐ Yes ☐ No If yes, complete supplement.
a. _____ (Name of Student) _____ (Name of School and Program of study) How many hours does the student attend school each week? _____ Is this considered full or part-time? ☐ Full-time ☐ Part-time	☐ Eligible student ☐ Ineligible student
b. _____ (Name of Student) _____ (Name of School and Program of study) How many hours does the student attend school each week? _____ Is this considered full or part-time? ☐ Full-time ☐ Part-time	☐ Eligible student ☐ Ineligible student
7. Do you usually buy food and prepare your meals with everyone who lives with you? ☐ Yes ☐ No **If no**, who buys and prepares their food separately? _____	
8. Have you or anyone in your household received cash assistance or SNAP benefits in Louisiana or from another state? ☐ Yes ☐ No a. If yes, who? _____ b. When? _____ c. What state(s)? _____	
9. Do you or anyone in your household have an application pending for any benefits that you are not receiving yet? ☐ Yes ☐ No	9. If yes, what type?
10. Has anyone in your household died or left your home since your last report or application? ☐ Yes ☐ No	10. If yes, complete supplement.
11. Did anyone move into your household since your last report or application? ☐ Yes ☐ No	11. If yes, complete supplement.

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E. Tell Us About Your Household's Work

Tell us about any money received by you or anyone in your household for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, military reserve pay, or work study. This includes money received from wages, salaries, tips, or commissions.

1. Do you or anyone in your household work? ☐ Yes ☐ No

*Complete the following information for **each person** who works for an employer. If anyone works for more than one employer, complete a separate block for each employer. Use plain paper if you need more space.*

2. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Paid by Direct Deposit? ☐ Yes ☐ No

If yes, at what bank or credit union? _____

If no, where do you cash your pay check? _____

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Is this job temporary? ☐ Yes ☐ No

If yes, date expected to end?

3. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Paid by Direct Deposit? ☐ Yes ☐ No

If yes, at what bank or credit union? _____

If no, where do you cash your pay check? _____

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Is this job temporary? ☐ Yes ☐ No

If yes, date expected to end? _____

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Use OFS 3

Verified by:

Is commission earned?
☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework?
☐ Yes ☐ No
Rate per piece?

Use OFS 3

Verified by:

Is commission earned?
☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework?
☐ Yes ☐ No
Rate per piece?

RETURN THIS PAGE TO YOUR LOCAL DCFS PARISH OFFICE

4. Is anyone on strike? ☐ Yes ☐ No

5. Has anyone in your household (including you) stopped working in the last 60 days? ☐ Yes ☐ No

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5. If yes, complete supplement.

*Complete the following information for **each person** who is self-employed. This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.*

6. Persons Who Are Self-Employed

Name	Name
Type of Business	Type of Business
Monthly Business Income	Monthly Business Income
Monthly Business Expenses	Monthly Business Expenses
# Hours Worked Per Week	# Hours Worked Per Week

6. Verified by:

☐ Prior year's income tax return

☐ Accountant or bookkeeper records

☐ Personal business records

7. Is anyone in your household (including you) looking for work? ☐ Yes ☐ No

8. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

9. Do you or anyone in your household rent a room? ☐ Yes ☐ No

10. Do you or anyone in your household pay someone else in your home for meals? ☐ Yes ☐ No

7. If yes, complete supplement.

F. Tell Us About Other Income

1. Do you or anyone in your household receive money from a source other than work? ☐ Yes ☐ No **If yes**, check each type of income.

- ☐ Annuity Income
- ☐ Child Support Income
- ☐ Contributions From Family/Friends
- ☐ Disability Insurance Benefits
- ☐ Energy Check
- ☐ Interest Income
- ☐ Loans
- ☐ Military Allotment
- ☐ Oil Lease/Royalties
- ☐ Railroad Benefits
- ☐ Rental Income
- ☐ Retirement Pension
- ☐ Roomer/Boarder
- ☐ Social Security
- ☐ Scholarships/Grants/School Loans
- ☐ SSI
- ☐ Spousal Support/Alimony
- ☐ Tribal Money
- ☐ Training Allowance (WIOA)
- ☐ Trust Income
- ☐ Unemployment Benefits
- ☐ Veterans Benefits
- ☐ Workers Compensation
- ☐ Other

For Office Use Only		FITAP		SNAP	
Name	**Age**	**WR Code**	**Reason For Exemption**	**WR Code**	**Reason For Exemption**

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2. *For each box checked in #1 of this section on page 5, complete the following information. Include any money you expect to receive in the next 30 days.*

Name	Type Of Income	Amount	How Often (Weekly, Monthly, etc)	Do You Expect This Income To End
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?

3. Is someone court-ordered to pay child support to you or anyone in your household? ☐ Yes ☐ No

4. Do you or anyone in your household receive any money from a child's parent who is not court-ordered to pay? ☐ Yes ☐ No

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Verified by:

3. If yes, complete supplement.

4. If yes, complete supplement.

G. Tell Us About Your Expenses

In order to receive the most benefits possible, you need to tell us about your household expenses. Failure to report any of the expenses listed below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

Living Arrangement

- ☐ Public housing
- ☐ HUD or Section 8 subsidy
- ☐ Other subsidy
- ☐ No rent subsidy

HOUSING EXPENSES

1. Check each type of housing expense that you or anyone in your household has.

- ☐ Rent
- ☐ Mortgage(s), (if buying)
- ☐ Lot Rent
- ☐ Homeowner's Insurance
- ☐ Flood Insurance
- ☐ Property Tax
- ☐ Condominium Fees
- ☐ Electricity
- ☐ Gas
- ☐ Sewer
- ☐ Water
- ☐ Garbage
- ☐ Telephone
- ☐ Other

Are insurance and property taxes included in the mortgage payment? ☐ Yes ☐ No

Are any of these bills past due?

☐ Yes ☐ No

2. *For each box checked in #1 of this section, complete the following information.*

Type Of Housing Expense	Name and Phone Number of Person or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

Indicate how each expense was verified.

Eligible for:
- ☐ SUA
- ☐ BUA
- ☐ TEL
- ☐ None

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3. Do you pay housing expenses for a home you are no longer living in but plan to return to? ☐ Yes ☐ No
4. Is your household responsible for paying a utility bill for using a heater or air conditioner? ☐ Yes ☐ No
5. Does anyone help you pay your housing expenses? ☐ Yes ☐ No
6. Do you receive energy assistance? ☐ Yes ☐ No
   If yes, is the assistance through the Low-Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No
7. Is any of the rent you pay used to pay utilities? ☐ Yes ☐ No

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5. If yes, complete supplement.

DEPENDENT CARE EXPENSES

1. Do you or anyone in your household pay someone to care for a child, or an adult who is elderly or disabled, so that you or a household member can work, attend training or school, or look for work? ☐ Yes ☐ No
2. **If yes**, complete the following information.

1. If yes, complete the OFS 4DC – Dependent Care Expense Worksheet.

Certified for CCAP?
☐ Yes ☐ No

What is co-payment amount?

When management is questionable, use form OFS 4MW.

Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

CHILD SUPPORT EXPENSES

1. Does anyone in your household pay court-ordered child support? ☐ Yes ☐ No
   If yes, complete the following information.

Court-ordered child support expenses:

Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

MEDICAL EXPENSES

We can allow a medical deduction in your SNAP case for each household member who has a disability or is over the age of 59. A deduction may be given for medical expenses that are ***more than $35.00 per month.***

1. Is there anyone in your household who has a disability or is over the age of 59? ☐ Yes ☐ No
   If yes, answer the questions in this section.
   If no, skip to the Household Resources section on the next page.
2. Does this person have to pay medical expenses? ☐ Yes ☐ No
   a. **If yes**, do you want to verify these expenses so that you can receive a medical deduction? ☐ Yes ☐ No
   b. Check each medical expense that this person has.

- ☐ Dental Bills
- ☐ Hospital Bills
- ☐ Health Insurance Or Medicare Premiums
- ☐ Medical Appliances
- ☐ Prescribed Medicine
- ☐ Prescription Drug Plan Premium
- ☐ Nursing Home
- ☐ Other

Medical expenses:
Use form SNAP 1MW

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3. *For each box checked in #2 on page 7, complete the following information.*

Names	Type of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc. This includes miles driven in your own vehicle.

4. Does any elderly or disabled person listed above have medical transportation costs? ☐ Yes ☐ No

   a. Does this person use their own vehicle or a household member's vehicle? ☐ Yes ☐ No

   b. **If yes**, complete the following information.

Name Of Person	List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	# Of Miles Traveled Round Trip	Number Of Visits Per Month

   c. Does this person pay someone other than a household member for medical transportation? ☐ Yes ☐ No

   d. **If yes**, complete the following information.

Name Of Person	Who Is Paid	Where Does This Person Go	How Much Does This Person Pay Per Trip	How Many Trips Does This Person Pay For Each Month

If you need more space, you can write the information on plain paper.

5. Will you or anyone in your household be reimbursed for any of the medical expenses listed above? ☐ Yes ☐ No

6. Does anyone help pay the medical expenses? ☐ Yes ☐ No

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5. If yes, complete supplement.

6. If yes, complete supplement.

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H. Tell Us About Your Household's Resources

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Resources include cash, money in the bank, Certificates of Deposit, stocks, and bonds. Resources do not include personal property such as jewelry, furniture, electrical equipment, or clothing.

1. Check each resource listed below that you or anyone in your household has.

- ☐ Bank/Credit Union Account (Checking)
- ☐ Bank/Credit Union Account (Saving)
- ☐ Joint Account
- ☐ Bonds
- ☐ Cash On Hand
- ☐ Certificate Of Deposit (CD)
- ☐ Money Market Account
- ☐ Mutual Funds
- ☐ Savings Bond
- ☐ Stocks

2. *For each box checked above, complete the following information.*

In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Etc.)

Are liquid resources $1500 or less? ☐ Yes ☐ No

3. Have you or anyone in your household received a Federal tax refund in the last twelve months? ☐ Yes ☐ No

3. If yes, complete supplement.

4. Have you or anyone in your household received or do you or anyone in your household expect to receive a lump sum of money? ☐ Yes ☐ No

4. If yes, complete supplement.
☐ Countable lump sum
☐ Non-countable lump sum
How was this verified?

5. Does your name or the name of anyone in your household appear on a bank/credit union account with someone else? ☐ Yes ☐ No

☐ Client statement
☐ Bank statement
☐ Other

a. **If yes**, whose names are on the account? _____
b. Why is this name on the account? _____
c. Does someone else make deposits into this account? ☐ Yes ☐ No
d. **If yes**, who and how much per month? _____

6. Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months? ☐ Yes ☐ No

6. If yes, complete supplement.

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IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY, SKIP TO PAGE 12.

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Complete This Page Only If You Are Applying for FITAP or KCSP

I. FITAP OR KCSP

1. Are you applying or reapplying for FITAP or KCSP? ☐ Yes ☐ No
   If yes, complete this page. **If no**, skip to page 12.
2. Do you or anyone in your household need to get away from an abusive situation? ☐ Yes ☐ No
3. Are immunizations current on all children? ☐ Yes ☐ No
   If no, who? _____ Why? _____
4. Are you or anyone in your household pregnant? ☐ Yes ☐ No
   If **yes**, who? _____ Due date: _____

HEALTH INSURANCE

5. Can you or anyone in your household get health insurance through an employer? ☐ Yes ☐ No

COLLATERALS

6. Please complete the following information for two people who are not related to you who can verify your household situation.

Name	Address	Daytime Phone Number

CUSTODY

7. If you are not the parent of the child(ren) for whom you are applying, do you have custody? ☐ Yes ☐ No
   a. **If yes**, complete the following information.

Children For Whom You Have Custody	Type Of Custody	Effective Date Of Custody

A non-custodial parent is a parent who does not live in the home with his/her child. Tell us about the non-custodial parent(s) of each child living in your home. This includes both mother and father if you are not the parent of the child(ren). If a child's biological father and legal father are not the same person, give the requested information for both fathers. Use plain paper if you need more space.

8. **Non-Custodial Parent Information**

Name | Social Security Number | Date of Birth

Street Address

City | State | Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents): ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced

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2. If yes Issue Flyer DV

3. Verification: ☐ OFS IM ☐ CR 9 ☐ LINKS

5. If yes, provide BHSF Flyer LaHIPP.

*Note: If client checked "Yes" for #5 on page 3, complete OFS 90 or OFS 90L.

7. Custody verified by:

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9. **Non-Custodial Parent Information**		
Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents):	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

10. **Non-Custodial Parent Information**		
Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents):	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

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Living in the home with qualified relative? ☐ Yes ☐ No

Verified by:

- ☐ Landlord statement
- ☐ School records
- ☐ Collateral
- ☐ Other

NCP: Complete form 4NCP and 4NCP Supplement, if applicable:

RETURN THIS PAGE TO YOUR LOCAL DCFS PARISH OFFICE

Read Carefully And Sign Below

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the felony conviction of certain crimes and the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain financial or food assistance. By signing this application, I give permission for the release of information to the Department of Children and Family Services by any persons or agencies who have knowledge of my circumstances.

Remember, you must turn in proof of the information you reported on this application form.

Your Signature (or mark)	Date Signed
Signature (or mark) of your wife or husband	Date Signed
Signature of Minor Unmarried Parent	Date Signed

If you, or your wife or husband, sign with an "X" mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

Witness	Witness	Witness

Signature of Person Who Helped You Complete this Form and His or Her Relationship to You

Signature	Relationship
Signature of Agency Representative	Date

Mail	Fax	Online	In Person
Department of Children and Family Services ES Document Processing Center P. O. Box 260031 Baton Rouge, LA 70826-9918	(225) 663-3164	CAFÉ' Customer Portal www.dcfs.la.gov/CAFE	Any DCFS Office

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

☐ I want to register to vote. ☐ I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote **will not** affect the amount of assistance that you will be provided by this agency. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in 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.

(Check one)

☐ **Yes, I would like help.** ☐ **No, I do not want help.**

For assistance in completing the voter registration application form outside our office, contact the Department of Children and Family Services at 1-888-LAHELPU or 1-888-524-3578.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to the DCFS ES Document Processing Center at P.O. Box 260031, Baton Rouge, LA 70826-9918.

Signature or Mark	**Name Typed or Printed**	**Date**

Signatures of Two Witnesses If Signed With Mark:

1) _____ 2) _____

COMPLAINTS

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 Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling (225) 922-0900 or 1-800-883-2805.

Comments/Remarks: (for official use only)

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Louisiana Voter Registration Application
(LA-VRA - Rev. 3/19)

SEE THE OTHER SIDE OF THIS PAGE FOR INSTRUCTIONS ➔

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

OFFICIAL USE ONLY: WD: _____ PCT: _____ REG. TYPE: _____ IN/OUT: _____ REG # _____

Please print clearly in ink, preferably black.

Reason for Application: ☐ New Voter Registration ☐ Updating Voter Registration

Eligibility

1. Are you a citizen of the United States of America? ☐ Yes ☐ No
   Will you be 18 years of age on or before election day? ☐ Yes ☐ No
   If you answered "**No**" to these questions, do not complete this form. You are not eligible to vote at this time.
   (Please see application instructions for information regarding eligibility to register prior to age 18.)

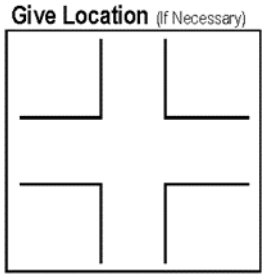
Name

2. LAST NAME: _____ FIRST NAME: _____
   FULL MIDDLE OR MAIDEN NAME: _____ SUFFIX (Sr., Jr. ,II) _____

Residence Address (Where you live and claim homestead exemption, if any)

3. HOUSE # & STREET (NO P.O. BOX): _____ UNIT/APT #: _____
   CITY/TOWN: _____ STATE LA ZIP CODE: _____

Give Location (If Necessary)



Mailing Address (If different from Residence Address)

☐ Check if no postal service at your residence address above and supply mailing address here.

HOUSE # & STREET/P.O. BOX: _____ UNIT/APT #: _____
CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

Birthdate

4. ____/____/____ MM DD YYYY

5. ***SSN** _____ - _____ - _____ XXX XX XXXX

6. **Sex** ☐ M ☐ F

7. **Race** (Optional) ☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER _____

Party Affiliation

8. ☐ DEM ☐ GRN ☐ IND ☐ LBT ☐ REP ☐ NO PARTY ☐ OTHER (Specify) _____

Place of Birth

9. CITY/TOWN: _____ STATE: _____ PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name

10. _____

Email (Optional)

11. _____

Phone (Optional)

12. Home: (_____) _____ - _____ Other: (_____) _____ - _____

LA DL/ID Card #

13. _____ ☐ I do not have a LA DL/ID card

Do you need assistance in voting?

14. ☐ No ☐ Yes, Reason: _____

Place of Last Residence

15. HOUSE # & STREET: _____ CITY: _____ STATE: _____

Place of Last Registration

16. STATE: _____ PARISH/ COUNTY: _____

Former Registered Name, if any

17. _____

Affirmation and Signature (read and sign or make your mark)

18. I do hereby solemnly swear or affirm that I am a United States citizen, that I am of eligible age to register to vote, that I have not been incarcerated pursuant to an order of imprisonment for conviction of a felony within the past five years, nor am I under an order of imprisonment for a felony offense of election fraud or other election offense pursuant to R.S. 18:1461.2, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $2,000 ($5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both. Any false statement may constitute perjury.

Applicant Signature: ☒ _____ Date: _____

Witnesses (If your signature is a mark, you must have two witnesses sign)

19. Witness #1 Signature: ☒ _____ Witness #1 Print Name: _____
    Witness #2 Signature: ☒ _____ Witness #2 Print Name: _____

*** Last 4 digits of the social security number are required, if issued, and you have no LA driver's license or LA special ID; full SSN number is preferred but optional.**

Note: If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. You may request a copy of your voter registration form at any time from the registrar of voters.

OFFICIAL USE ONLY

☐ New Registration Updated Registration: ☐ Address Change ☐ Name Change ☐ Party Change ☐ Change to Assistance in Voting

REMARKS:

CIRCLE ONE: PA MV RG SDA SS (Disability) Received by: _____ Date: _____

Louisiana Voter Registration Application
(LA-VRA - Rev. 3/19)

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

APPLICATION INSTRUCTIONS

USE THIS LOUISIANA VOTER REGISTRATION APPLICATION TO: 1) register to vote; 2) change your address; 3) request a name change; 4) change party affiliation; or 5) request assistance in voting.

TO REGISTER AND BE ELIGIBLE TO VOTE AN APPLICANT MUST: 1) be a U.S. citizen; 2) be at least 17 years old (16 years old if registering to vote in person at the Registrar's Office or with an application for a Louisiana driver's license) but must be 18 years old before actually voting; 3) not be under an order of imprisonment for conviction of a felony or, if under such an order not have been incarcerated pursuant to the order within the last five years and not be under an order of imprisonment related to a felony conviction for election fraud or any other election offense pursuant to R.S. 18:1461.2; 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended; 5) reside in the state and parish in which you seek to register and vote.

Instructions: the grey section numbers on this page correspond to the grey section numbers on the application.

Reason for Application: Check "New Voter Registration", if this is a first time registration or if a new registration in a new parish after moving. Check "Updating Voter Registration", if you are making any change to your present registration. If new registration, fill out the form completely.

1. *Eligibility* - Federal law requires you to affirm that you are a citizen of the United States of America and that you will be 18 years of age on or before the election day in which you are eligible to vote. If you answered "No" to these questions, do not complete this application form. You are not eligible to vote at this time. If you are registering as a 16 or 17 year old, you may check "Yes" because you will not be allowed to vote until you are 18.
2. *Name* - You **must** provide your full name. Do not use nicknames or initials for middle or maiden name. *If this application is for a change of name, please also complete section 17: "Former Registered Name".*
3. *Residence Address* - "Residence Address" means the address (Number, Street, City, State and Zip) where you live and are registering to vote. Residence address **must** be the address where you claim homestead exemption, if any, except for a resident in a nursing home or veterans' home who may choose to use the address of the nursing home or veterans' home or the home where they have a homestead exemption. A college student may elect to use their home address or their address at school while attending. Do not use a post office box for your "Residence Address". If you use a rural route and box number, you may draw a map in box labeled "Give Location" to provide the exact location. Write in the names of the crossroads (streets) nearest to residence. Draw an X to show residence. Use a dot to show any schools, churches, stores or landmarks near residence and write the name of the landmark.

   Mailing Address - If you check that you do not receive postal service at your residence address, you **must** provide your mailing address (Number, Street, City, State and Zip). Otherwise a mailing address may be provided and you may use a Post Office Box for a mailing address.
4. *Birthdate* - Print your date of birth. *The month and day of your birth remains confidential by law.*
5. *Social Security Number* - If you do not have a LA driver's license or LA special identification card, you **must** provide the last four digits of your social security number, if issued. The full social security number is preferred and may be provided on a voluntary basis and will be kept confidential. If you were not issued a social security number, you **must** attach either one or more documents to prove your identity, residence and date of birth. Documents may be: a) a copy of current and valid photo identification and/or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document. *Your SSN number remains confidential and is only used for registration purposes.*
6. *Sex* - Check male or female *(for statistical purposes only).*
7. *Race* - Race/Ethnic origin is optional *(for statistical purposes only).*
8. *Party Affiliation* - If you are registering for the first time, you may choose a party affiliation of Democrat, Green, Independent, Libertarian or Republican parties. You may specify any other party affiliation by checking "other" and then listing the party you wish to affiliate. If you do not want to register with a political party affiliation check "No Party", or if you do not complete this section, your party affiliation will be listed as "no party". If you are already registered with a party affiliation and no political party change is being made with this application, you may leave this section blank or re-enter your political party affiliation.
9. *Place of Birth* - Print the city/town, parish/county, state and country of your birth place *(for statistical purposes only).*
10. *Mother's Maiden Name* - Print your mother's maiden name, which is her last name at her birth. If unknown, write "unknown".
11. *Email* - Give your email address for election officials to contact you if there is a problem with your registration. *Email addresses are protected from disclosure by law and are for official use only.*
12. *Phone* - Give your phone numbers for election officials to contact you if there is a problem with your registration. *Phone numbers are optional and a public record unless you make a request for your phone numbers to be kept confidential by election officials.*
13. *LA DL/ID Card #* - Print your LA driver's license or LA special identification card number, if issued. If you do not have one, check "I do not have a LA DL/ID card". *This ID number remains confidential and is for official use only.*
14. *Assistance in Voting Needed?* - Indicate if you will need assistance in voting by checking either the "No" or "Yes" box. If "Yes", write the reason for needing assistance. The registrar of voters in your parish may contact you for proof of disability.
15. *Place of Last Residence* - Print the address (number and street), city, and state of your prior residence, if different from residence address in section 3 or write "Same".
16. *Place of Last Registration* - Print the state and parish (or county) of your last registration if you were registered in another parish or state prior to completing this application. ***Important:*** *Contact the local election office in your prior state and cancel your prior registration. Registering in Louisiana does not automatically cancel or transfer your voter registration from another state.*
17. *Former Registered Name* - If you are using this application to make a name change to your registration, print your former registered name (name you are changing) in this section. If name changed by court order, provide a copy of the order with this application.
18. *Affirmation and Signature* - Read the affirmation and sign your full name or make your mark and print the date this application was signed and completed. *If assistance in registering is being provided, make sure the applicant understands what they are affirming and that they meet the requirements to register to vote.*
19. *Witnesses* - If you are unable to sign your name, you may make your mark, but it **must** be witnessed by two people or it is not valid.

Mailing Instructions - If returned by mail, place in an envelope and mail to your Registrar of Voters Office. You can find your registrar of voters mailing address on the Registrar of Voters Address Page, by visiting our website at www.geauxvote.com or by calling the toll free at 1-800-883-2805. Your application or envelope **must** be postmarked 30 days prior to the first election in which you seek to vote.

Online Voter Registration - Voter registration is also available at www.geauxvote.com and you may register online before the 20th day prior to the election. Please call your registrar of voters if you do not receive your voter information card two weeks after registering.

KEEP THIS PAGE FOR YOUR RECORDS

What will we do with the information that you provide?

- Information you give us on your application will be verified by federal, state, and local offices including computer cross-matching with other agencies. Someone from our agency may contact other people in order to verify your eligibility for benefits.

- The alien status of household members is subject to verification through the United States Citizenship and Immigration Service (USCIS) and may affect eligibility and benefit amount.

Why do we need your Social Security Number and are you required to provide it?

- The collection of information requested on the application form, including Social Security Numbers (SSNs) of household members, is voluntary and authorized under the Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036), as amended. Failure to provide required information including SSNs for household members will result in ineligibility for SNAP and cash assistance.

- SSNs are used in state and federal program reviews, audits, and computer-matching with other agencies such as Louisiana Workforce Commission, Social Security Administration, Internal Revenue Service, etc. through the State Income and Eligibility Verification System.

- SSNs are used to:

    - collect information from other sources,
    - check identity of household members,
    - determine whether your household is eligible, and
    - prevent households from getting more benefits than they are entitled to receive.

- Under the Privacy Act of 1974 (P.L. 93-579), SSNs may be released for various reasons including those directly connected to the administration of the Child Support Enforcement Program.

Rights and Responsibilities

When you receive benefits from the Louisiana Department of Children and Family Services, you have certain rights and responsibilities that are explained below. Keep this important information for future reference.

What are your rights?

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD 3027), found online at: https://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C.20250.9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: https://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C.20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You may file a civil rights complaint with the Department of Children and Family Services (DCFS) by completing the Civil Rights Complaint Form. Turn the form in to a local office; mail it to DCFS Civil Rights Section, P O Box 1887, Baton Rouge, LA 70821; email DCFS.BureauofCivilRights@LA.GOV, or; call (225) 342-0309. You may file a civil rights complaint with DCFS and USDA or only DCFS.

A program complaint may be filed with the Department of Children and Family Services (DCFS) by emailing LaHelpU.DCFS@LA.GOV or by calling 225-342-2342.

- **Fair Hearing** - If you do not agree with any decision made on your case, you have the right to ask that your case be reviewed. You can do this by contacting us at the local parish office and requesting a fair hearing in writing, in person, or by calling the office. You have the right to look at your case record before the hearing.

- **Confidentiality** - All the information you give us is confidential. This means that we cannot give information about your case to other people except under special conditions. Examples of those conditions include official review by other State and Federal agencies, or Federal, State, and private collection agencies for the collection of claims against SNAP benefits. Information from your case may also be given to law enforcement officials for the purpose of catching persons fleeing to avoid the law and for investigation of a felony or probation/parole violation.

- **Voter Registration** - If you are not registered to vote where you live now, you may indicate that you would like to apply to register to vote on the Application for Assistance. Please note that the information you give to the agency will remain confidential and will be used only for voter registration purposes. Applying to register or refusing to register to vote will not affect the amount of assistance or services that you may receive from the Department of Children and Family Services. DCFS will assist you with completing a Louisiana Voter Registration Application, unless assistance is refused. You may fill out the application form in private.

What are your responsibilities?

- **Cooperation** - You have to cooperate by providing the information we need to determine your eligibility. You also have to provide proof of the information you report. You will be expected to cooperate if a home visit is necessary to determine your eligibility. If your case is selected for a quality control review by state or federal reviewers, you have to cooperate with them.

- **Report changes** –
  If you receive SNAP benefits, you must report if:
  - Your household's monthly income increases to more than the SNAP gross income limit for your household size. This includes reporting the income of a person who moves into your home if that person's income combined with your SNAP household's income is more than the gross income limit for your household.
  - Your household includes an Able-Bodied Adult Without Dependent (ABAWD), you must report changes in work hours of the ABAWD who is subject to the SNAP time limit if the change results in the ABAWD working an average of less than 20 hours or less than 80 hours per month.
  - Your household receives lottery or gambling winnings of $3500 or more, won in a single game before taxes or other withholdings.

  These changes must be reported by the 10th of the month following the month in which the change occurs.

  In addition, if you are receiving:
  - FITAP - You have to:
    - Follow the reporting requirements explained in your Family Success Agreement and report these changes within 10 days of your knowledge of the change.
    - Report within 10 days if the only eligible child receiving FITAP benefits moves out of your home.
  - KCSP - You have to report within 10 days if the only eligible child receiving KCSP benefits moves out of your home.

  If you are **not** receiving SNAP benefits, **and are** receiving:
  - FITAP or KCSP - You have to report within 10 days if:
    - There is a change in the source of any income received in your household. This includes changes in employers and new sources of income such as child support, Social Security, SSI, etc.
    - The amount of your household's unearned income changes by more than $50 per month.
    - The amount of your household's earned income changes by more than $100 per month.
    - Someone moves into or out of your household.
    - You move.
    - School attendance of any 18 year old in your household.
    - Marital status of anyone in your household.

Information on Non-Cash Services

Your household may be authorized to receive the following non-cash TANF/MOE funded services. For additional information, please visit our website at www.dcfs.louisiana.gov or contact your local DCFS Office.

- **Family Violence Prevention and Intervention Program** - Provides services for victims of domestic violence and their children. Services are limited to children and/or parents/caretaker relatives who are victims of domestic violence. Call 1-888-411-1333.

- **Jobs for America's Graduates LA (JAGS-LA) Program** - Helps keep in school students (age 12 through 21) at risk of failing who face at least two barriers to success which may include economic, academic, personal, environmental, or work related barriers; assists out-of-school youth in need of a high school education; provides an avenue for achieving academically; and assists students in ultimately earning recognized credentials that will make it possible for them to exit school and enter post-secondary education and/or the workforce. Call 225-219-0368.

- **Nurse Family Partnership Program** - Serves low-income, first-time mothers who are no more than 28 weeks pregnant by providing nurse home visitation services beginning early in pregnancy and continuing through the first two years of the child's life. Call 504-219-9520 or 337-898-6097.

- **Court Appointed Special Advocates (CASA)** - Enhances family stability by facilitating links between the particular child/family and community resources/systems through trained, qualified, and supervised advocates who provide skilled communication, necessary transportation, efficient and thorough information gathering, and other services identified in an individual case. Call 225-930-0305 and 1-888-567-2272.

- **Drug Court Programs** - Combines both treatment and educational components with the ability of a supervising judge to award incentives and sanctions based upon the performance of the clients while in treatment. Treatment is community-based and drug court participants are required to meet with the judge on a regular basis to review progress. Call 504-568-2020.

- **Alternatives to Abortion** - Provides intervention services including crisis intervention, counseling, mentoring, support services, and pre-natal care information, in addition to information and referrals regarding healthy childbirth, adoption, and parenting to help ensure healthy and full-term pregnancies as an alternative to abortion.

- **LA 4 Public Pre-Kindergarten Program** - Provides high quality early childhood education for low income 4-year-olds in participating public school districts and Charter schools.

Penalties	
If you knowingly report incorrect information, your SNAP benefits or cash assistance may be denied, reduced, or ended and you may be subject to criminal prosecution.	
What penalties apply in the SNAP?	
If you do the following:	**You will:**
● Hide information or give false information ● Trade or sell SNAP benefits or EBT cards ● Use SNAP benefits to buy ineligible items, which includes alcohol, tobacco, hot food, and any food sold for on-premises consumption. Nonfood items are also not allowed. ● Use someone else's SNAP benefits ● Pay for food purchased on credit with SNAP benefits	Lose your SNAP benefits for: ● 1 year for the first violation ● 2 years for the second violation ● Permanently for the third violation You may also be fined up to $250,000 or imprisoned for up to 20 years or both.
If you do the following:	**You will:**
● Trade SNAP benefits for illegal drugs	Lose your SNAP benefits for: ● 2 years for the first violation ● Permanently for the second violation
● Trade SNAP benefits for firearms, ammunition, or explosives ● Trade, buy, or sell SNAP benefits of $500 or more	● Lose your SNAP benefits permanently
● Give false information about who you are or where you live in order to receive benefits in more than one case at the same time	● Lose your SNAP benefits for 10 years
What penalties apply in FITAP and KCSP?	
If you do the following:	**You will:**
● Hide information or give false information	Lose your benefits for: ● 1 year for the first violation ● 2 years for the second violation ● Permanently for the third violation You may also be fined up to $50,000 or imprisoned for up to 20 years or both.
● Use your EBT card: ➢ in a liquor store, ➢ in a gambling casino or gaming establishment, ➢ in a retail establishment that provides adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes, ➢ at any adult bookstore, any adult paraphernalia store, or any sexually oriented business, ➢ at any tattoo, piercing, or commercial body art facility, ➢ at any nail salon, ➢ at any jewelry store, ➢ at any amusement or video arcade, ➢ at any bail bonds company, ➢ at any night club, bar, tavern, or saloon, ➢ on any cruise ship, ➢ at any psychic business; or	Lose your benefits for: ● 1 year for the first violation ● 2 years for the second violation ● Permanently for the third violation

➢ at any establishment where persons under age 18 are not permitted, or ➢ at an ATM in any of these establishments ● Use your EBT card at any retailer for the purchase of an alcoholic beverage, tobacco products, lottery tickets, or jewelry.	
● Give false information about where you live in order to receive benefits in two or more states at the same time	● Lose your benefits for 10 years

For more information about programs and services or for specific information about your case, call 1-888-LAHELPU (1-888-524-3578).

Case Name: _____ Case ID: _____

VERIFICATION OF CONTRIBUTIONS TO BE COMPLETED BY PERSON WHO GIVES YOU HELP

Carefully Read the Following and Indicate the Ways You Help:

1. Contributions (MONEY YOU DO NOT EXPECT TO BE REPAID)

   Have you given money directly to the above-named person or any member of this household in the last two months? ☐ Yes ☐ No

   If yes, please list the amounts given and the reason given. For example: To help support your child, to help pay their rent, utilities, etc.

Date Given	Amount	Reason Given

   Do you plan to continue these contributions on a regular basis? ☐ Yes ☐ No

   If yes, amount? _____ How often? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice Monthly

2. Loans (MONEY YOU EXPECT TO BE REPAID)

   Have you loaned money directly to the above-named person or any member of this household in the last two months? ☐ Yes ☐ No

   If yes, amount? _____ How often? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice Monthly

3. Payments to someone else (MONEY NOT GIVEN DIRECTLY TO A HOUSEHOLD MEMBER)

   Have you paid rent, utilities, medical or other bills directly to a company or person out of the home for the above-named person or any other member of this household in the last two months? ☐ Yes ☐ No

   If yes, please list details below:

Expense Paid	Amount Paid	Who Was Paid	How Often Paid (Weekly, Monthly, Etc.)

4. Do you help anyone in this household in any other way? ☐ Yes ☐ No

   If yes, explain:

   _____

   _____

   _____

Your Signature: _____ Date: _____

Telephone number where you can be reached during the day: _____ - _____ _____

Address: _____

Please use back of form for additional space or to explain any of the above information.

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WAGE VERIFICATION
TO BE COMPLETED BY EMPLOYER IF CHECK STUBS ARE NOT AVAILABLE

Name of Employee: _____ SSN: _____

Name of Employer: _____ Date Employment Started: _____

Check how often employee is (was or will be) paid (i.e. PAY PERIOD).

☐ Weekly ☐ Twice Monthly (pay dates): _____

☐ Every two weeks ☐ Monthly

Is the employee paid by Direct Deposit? ☐ **Yes** ☐ **No**

If yes, at what bank or credit union? _____

If employment is new:

Number of hours expected to work **per WEEK** _____ **per PAY PERIOD** _____

Hourly rate of Pay _____

Number of hours of overtime expected to work **per WEEK** _____ **per PAY PERIOD** _____

Hourly rate of overtime pay _____

If Tips are expected to be received, amount of Tips **per WEEK** _____ **per PAY PERIOD** _____

First check date: _____ Pay period ending: _____ Anticipated gross amount of first check : _____

Complete chart below to show wages for the last 4 pay periods.

Pay Period Ending	Date Wages Received Or Anticipated	Hours Worked	Hourly Pay Rate	Gross Pay	Tips Received

Is there an anticipated change in the number of hours or rate of pay? ☐ Yes ☐ No

If yes, Date of Change? _____

What type of change is anticipated? _____

Number of hours expected to work per week _____ Per pay period _____ Hourly rate of pay _____

Has the employee voluntarily and without good cause quit or reduced their work hours in order to work less than 30 hours per week? ☐ Yes ☐ No

If yes, explain: _____

Are you aware of any other income this person may be receiving? **If yes**, source and amount:

If employment terminated, give date and reason no longer employed. _____

Date Signed _____ Employer's Signature _____ Employer's Phone Number

Employer's Printed Name or Stamp