WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

If you wish to report changes for your SNAP benefits, you may use this form to do so. This will help make sure you get the correct benefits you are eligible to receive. If you receive SNAP benefits, you are not required to report changes except when the gross earned and unearned income of everyone who lives in your home exceeds the gross income limit for your assistance group's size and, or if your household contains an Able-Bodied Adult Without Dependents (ABAWD), defined as someone at least 18 years old but not yet 50, when that person's work hours are reduced to less than 20 hours a week, averaged monthly. The gross income limit for your assistance group can be found on any recent notification letter or may be obtained by contacting the Customer Service Reporting Center. However, any changes that you choose to report will be acted on for all programs if required. If you are unsure of the reporting requirements for the benefits you receive, please contact the Customer Service Reporting Center at 1-877-716-1212 before reporting information.

If you intentionally give FALSE INFORMATION or WITHHOLD INFORMATION, you will have to pay back your SNAP benefits and may be disqualified from SNAP for 12 months, 24 months or permanently. In addition, you may be found guilty of FRAUD. Punishment upon conviction may be a fine up to $250,000 or a jail sentence of up to 20 years.

Name (Please print): _____ Case Number: _____

SIGNATURE: _____ DATE: _____

Social Security Number: _____ Telephone Number: _____

1. Please check one of the following boxes:

   ☐ The changes I am reporting are only for this month.

   ☐ The changes I am reporting will be continuing.

2. If the address where you live has changed, please write your NEW address below.

   Street Address: _____ Apt. #: _____

   City, State: _____ Zip: _____ Phone: _____

   Directions to your home: _____

   _____

   If the address where you get your mail is different, please write your new mailing address below.

   Post Office Box #: ____ or Street Address: _____ Apt. #: ____

   City, State: _____ Zip: _____

3. Please enter the amount paid each month for the items below or zero (0) if you no longer pay this expense. If you now pay a shelter or utility expense that is not listed, please write it in the section listed as other. If any agency or individual not living in your home now pays all or part of these expenses, please list the amount that they pay and whether it is paid to you or directly to the company that bills you. PLEASE CIRCLE YOUR PRIMARY SOURCE OF HEATING OR COOLING.

Type of Expense	Amount Owed Each Month	Paid By (Self, HUD, etc.)
Rent/Mortgage Payment, Lot Rent, Property Tax, Homeowner's Ins., Etc.	$	
Electric	$	
Gas	$	
Propane	$	
Fuel Oil	$	
Sewer/Water	$	
Other	$	

4. Has anyone moved into or out of your household? Yes ☐ No ☐ If yes, complete the chart below.

Name	Date of Birth	Relationship to You	Date Moved In	Date Moved Out

5. Has anyone in the household changed his or her name? Yes ☐ No ☐ If yes, complete the chart below.

Old Name	Date of Birth	New Name	Reason For Name Change

6. Has there been a change in the income of anyone in the home? Yes ☐ No ☐

If yes, please list all changes and new sources of earned and/or unearned income received in your household.

Name	Source of Income	Gross Amount

7. Does anyone in your household have any new assets and/or a change in value for any of the following assets?
Yes ☐ No ☐

If so, list who and the current amount. Please also list accounts on which the name of any household member is listed, even if the other person does not live with you.

	Name	Amount
Checking accounts		
Savings accounts		
Stocks and Bonds		
Burial Funds		
Other Assets		

8. Does anyone in your household now pay or have a change in the amount they pay for court-ordered child support, other expenses, or medical insurance for a child? Yes ☐ No ☐

If yes, provide the following for each of the last 3 months:

Name	Month	Court-Ordered Amount	Payment Actually Made

9. Has an Able-Bodied Adult Without Dependents (ABAWD) included in your SNAP benefits had his/her work hours reduced to less than 20 hours a week, averaged monthly? If yes, please list the individual(s) below.

Name	Social Security Number