

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES

To: _____ Worker Name: _____
Address: _____ Office Address: _____
_____ Worker Phone: _____

Rhode Island Works Cash Assistance Program and the
Supplemental Nutrition Assistance Program
(Formerly known as the Food Stamp Program)

This is your Six Month / Interim Report. You must:

- Answer all of the questions on this form
- Sign and return this form to the DHS office listed above
- **PLEASE REMEMBER: You Must Sign the Signature Line.**

You do not have to come into the office at this time. If we have any questions about what you tell us, we will call you.

Please write a telephone number where you can be reached: _____.

If this form is not completed and returned by _____ your Cash Assistance
Due Date
and your SNAP benefits will end.

**YOU MUST ANSWER EACH SECTION BELOW AND PROVIDE VERIFICATION OF THE
INFORMATION REQUESTED IN THE QUESTIONS.**

SECTION 1 – ADDRESS / SHELTER EXPENSE INFORMATION

If the address listed above is not your current address, write your new address below. If your address has changed, you must enclose proof of your new address, shelter and utility expenses.

Even if your address has not changed, you may report and enclose proof of any change in shelter and utility expenses.

Do you have expenses where you currently live? YES NO

Provide proof/verification of all expenses that you list below, such as a copy of your lease, mortgage statement, tax bill, home insurance bill, heating or air conditioning bill.

Do you have an expense for Rent or Room	\$ _____	per _____
Mortgage	\$ _____	per _____
Property Taxes	\$ _____	per _____
Home Insurance	\$ _____	per _____

Do you pay the gas, oil, electricity or other bill for your main heating system? YES NO

Do you pay the electric bill or an extra assessment for your rent for air conditioning? YES NO

If you have no expenses for heating or cooling, list any other expenses for where you live:

Kind of expense _____ \$ _____ per _____
 Kind of expense _____ \$ _____ per _____
 Kind of expense _____ \$ _____ per _____

Does anyone in the household pay daycare costs for children or disabled adults due to work or schooling? YES NO

If YES, fill in the information below:

Name(s) of Person Paying for Care	Reason (circle one)
1. _____	working / looking for work / going to school
2. _____	working / looking for work / going to school

Name(s) of Those Receiving Care	Type of Care	Cost of Care/How Often	Is Cost Subsidized? (circle one)	Is Yes, Subsidy Amount
1. _____	Adult / Child	\$ _____ per _____	Yes / No	\$ _____
2. _____	Adult / Child	\$ _____ per _____	Yes / No	\$ _____
3. _____	Adult / Child	\$ _____ per _____	Yes / No	\$ _____

SECTION 2-- CHILD SUPPORT PAYMENTS

Is anyone living with you court-ordered to pay child support?

YES \$ _____ /month (Include Verification) NO

SECTION 3 – HOUSEHOLD MEMBERS

Fill in the boxes below about each person in your household. Use an additional sheet of paper if more room is needed.

Last Name	First Name	MI	Relationship to you SELF	Date of Birth	Social Security Number

SECTION 4 – HOUSEHOLD INCOME

Provide the following information for any person in your household who has any income from working, from renting property or from providing room/board or daycare. You must include proof of income for the past thirty days, e.g., paycheck stubs/tip reports, or if self-employed include signed statements of gross earnings and self-employment expenses.

Person with Income	Employer / Business	Amount / How Often
		Per
		Per
		Per
		Per

SECTION 5 – UNEARNED INCOME

Please provide the following information for any person in your household that has unearned income. Examples of unearned income are as follows: Social Security (RSDI, SSI), Unemployment Compensation, Alien Sponsorship, Child Support, Veteran’s Benefits, Dividends, Interest, Alimony, and TDI. You don’t have to report changes in your RI Works or GPA benefit.

Person with Income	Employer / Business	Amount / How Often
		Per
		Per
		Per
		Per

SECTION 6 - SIGNATURE

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge and belief. I know that under the State of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported. I understand that the information I provide on this form may result in a change or termination of my benefits.

SIGNATURE _____ DATE SIGNED _____

You have a RIGHT to non-discriminatory treatment. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Food Stamp Act; the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106); and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Rhode Island Executive Office of Health and Human Services (EOHHS) and the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation. For further information about these laws, regulations and EOHHS'/DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact EOHHS/DHS at 57 Howard Avenue, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Secretary of EOHHS and/or the Director of DHS or his/her designee has the overall responsibility for EOHHS'/DHS' civil rights compliance. In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, relation, political beliefs or disability. To file a complaint of discrimination for SNAP, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call (202) 720-5964 (voice and TDD). USDA is an Equal Opportunity provider and employer.

You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and SNAP Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

The chart below shows you some examples of the documents you will need to submit along with this Interim Report Form. Return this completed Interim Report form even if you don't have all of these documents. If you need assistance obtaining these documents, you may contact the worker listed on page 1 of this form.

Earned Income	Pay stubs or statement on employer letterhead showing income before taxes, pay dates, hourly work schedule and the number of hours worked for the past four weeks
Residence and Shelter Costs	Rent receipt, mortgage payment book, rent/lease agreement, statement from HUD, statement from person who shares shelter costs, utility bills, statement from utility company, statement from landlord
Child Support that You Pay	If your obligation to pay child support has changed, provide a copy of the court order.
Unearned Income	Most recent copy of Social Security check or award letter; proof of unemployment, worker's compensation, pension, child support, alimony, child support, TDI received
Dependent Care Expenses	Receipt showing your out-of-pocket child care expenses or expenses for caring for a disabled or elderly household member