



**Georgia Department of Human Services  
Division of Family and Children Services  
Supplemental Nutrition Assistance Program (SNAP)  
Periodic Report Form**



**If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).**

To continue receiving your SNAP benefits, we need to know if there have been any changes in your household's income or expenses. Please complete **the entire** form, sign it, and mail it to your county DFCS office **no later than the 5<sup>th</sup> of the month**. You can locate your local office at <http://dfcs.georgia.gov/locations>. You may submit this periodic report to your county office by mail, hand-delivery, or online at <https://www.gateway.ga.gov>. If you submit this report **after** the 5<sup>th</sup> of the month, there may be a delay in your benefits. If the **entire form** is not completed, and not signed and returned, your SNAP case will close.

Client First and Last Name	Date of Birth	Social Security Number
Street Address Where You Live		
City	State	Zip Code
Are you homeless? Yes ____ or No ____		
Mailing Address (If Different)		
We may use your numbers to call or text about your case. Main Telephone Number _____ Other Contact Number _____		
Electronic Communication: _____ Email Address (optional): _____ Email: Yes ____ or No ____ (optional) Text: Yes ____ or No ____ (optional)		
What is your Preferred Language?		If an interview is required, will you need an interpreter? Yes ____ or No ____

**Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):**

**Do you have a disability that will require Reasonable Modification or Communication Assistance? Yes\_\_ No\_\_ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):**

Sign Language interpreter\_\_\_\_; TTY\_\_\_\_; Large Print\_\_\_\_; Electronic communication (email)\_\_\_\_; Braille\_\_\_\_; Video Relay\_\_\_\_; Cued Speech Interpreter\_\_\_\_; Oral Interpreter\_\_\_\_; Tactile Interpreter\_\_\_\_; Telephone call reminder of program deadlines\_\_\_\_; Telephonic signature (if applicable)\_\_\_\_; Face-to-face interview (home visit)\_\_\_\_; Other:\_\_\_\_\_

**Do you need this Reasonable Modification or Communication Assistance one-time\_\_or ongoing \_\_?**

**If possible, briefly explain when and how long you need this modification or assistance?**

**Authorized Representative:**

Complete this section only if you want a person or an organization to fill out your periodic report, and/or use your EBT card to buy food when you cannot go to the store. Please check the box next to SNAP if you want to designate someone as your authorized representative. Please check which duties you want the person or organization to have.

Authorized Representative Program Type: SNAP ☐

Authorized Representative Duties: Sign application on applicant's behalf ☐ Complete and submit periodic report form ☐

Receive copies of notices and other communication ☐ Act on behalf of applicant in all other matters ☐



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Person Name: \_\_\_\_\_  
Organization Name (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Electronic Communication: Email: Yes \_\_\_ No \_\_\_ (optional)      Texting: Yes \_\_\_ No \_\_\_ (optional)  
Email Address (optional) \_\_\_\_\_  
Preferred Language: \_\_\_\_\_ Is an interpreter needed? Yes \_\_\_ or No \_\_\_

**Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance for Authorized Representatives (if applicable):**

**Does the Authorized Representative have a disability that will require Reasonable Modification or Communication Assistance? Yes\_\_\_ No\_\_\_ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):**

Sign Language interpreter\_\_\_; TTY\_\_\_; Large Print\_\_\_; Electronic communication (email)\_\_\_; Braille\_\_\_; Video Relay\_\_\_; Cued Speech Interpreter\_\_\_; Oral Interpreter\_\_\_; Tactile Interpreter\_\_\_; Telephone call reminder of program deadlines\_\_\_; Telephonic signature (if applicable) \_\_\_; Face-to-face interview (home visit) \_\_\_; Other: \_\_\_\_\_

**Does the authorized representative need this Reasonable Modification or Communication Assistance one-time\_\_\_ or ongoing\_\_\_? If possible, briefly explain when and how long you need this modification or assistance?** \_\_\_\_\_

**The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R.**

**§ 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members social security number(s).** Anyone who is living in your household and is not applying for benefits may be treated as a **non-applicant**. Non- applicants do not have to give us information about their social security number, citizenship, or immigration status and are not eligible for benefits. Other household members may still be able to receive benefits if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their social security number (SSN). You will still need to tell us about **their** income and resources to determine the eligibility and benefit level of the household. We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status. However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level. We will match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a SNAP claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status.



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**HOUSEHOLD COMPOSITION**

**Did anyone move into or out of your home since your last renewal or periodic report? Yes \_\_\_\_\_ No \_\_\_\_\_**

If yes, list the person and their relationship to you:

Name	Date Moved In/ Out	Relationship To You	Date of Birth	Social Security Number

**ADDRESS**

**Did you recently move and have a change in your shelter expenses? Yes \_\_\_\_ No \_\_\_\_** If yes, complete the information below:

Is your new address the same as the address written above on page 1? Yes \_\_\_\_ No \_\_\_\_

New Rent or Mortgage Amount \$ \_\_\_\_\_. If a mortgage, the annual property tax is \$ \_\_\_\_\_, and the amount for annual homeowner's insurance is \$ \_\_\_\_\_.

For rent, list your landlord's name and contact information: \_\_\_\_\_

Does anyone help you pay your rent, mortgage, or utilities? Yes \_\_\_\_ No \_\_\_\_ If yes, answer the following questions

Who pays the bills? \_\_\_\_\_ What bills are paid? \_\_\_\_\_

What amount is paid for each bill? (List each amount separately.) \_\_\_\_\_

\_\_\_\_\_ Who do they pay the bills to? \_\_\_\_\_

At your new address, what utilities do you pay for? \_\_\_\_\_

Do you pay heating or cooling costs? Yes \_\_\_\_ No \_\_\_\_ Circle one: electricity, gas, or both

Are you receiving energy assistance (LIHEAP)? Yes \_\_\_\_ No \_\_\_\_

**ABLE-BODIED ADULT WITHOUT DEPENDENTS (ABAWD)**

**Did your household have an Able-Bodied Adult Without Dependents (ABAWD) whose work hours fell below 20 hours per week or 80 hours per month? Yes \_\_\_\_ No \_\_\_\_** If yes, complete the information below:

What is the name(s) of the ABAWD who was working 20-29 hours per week or 80 hours per month?  
\_\_\_\_\_

How much did their work hours decrease by? \_\_\_\_\_

Did the household member(s) leave their employment? Yes \_\_\_\_ No \_\_\_\_

What was the reason for leaving the job? \_\_\_\_\_



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**INCOME**

Has anyone had a change in the wage rate, salary, full-time or part-time status or source of income received each month? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list information about your pay from employment such as wages, bonuses, and tips, and provide proof of ALL income received in the last thirty (30) days.

Who had a change in income or employment? \_\_\_\_\_

Where does the income or employment come from? \_\_\_\_\_

How often is the income received? (weekly, biweekly, semi-monthly, monthly) \_\_\_\_\_

Has anyone stopped working? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, complete the following and provide proof:

When did the income or employment stop? \_\_\_\_\_

What is the last payment amount received? \_\_\_\_\_

Has anyone started working? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, complete the following and provide proof:

When did the income or employment start? \_\_\_\_\_

What is the new amount of income? \_\_\_\_\_

**SELF-EMPLOYMENT:** Is anyone self-employed: Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, who?) \_\_\_\_\_

Please provide proof of self-employment income through tax files, business records, receipts, bills, or statements from customers of an established business.

Is this business incorporated? ☐ Yes ☐ No

Does this person have any self-employment expenses? ☐ Yes ☐ No

If yes, what type of expenses does this person have? \_\_\_\_\_

**UNEARNED INCOME:**

Has anyone in your household had a change in unearned income of more than \$100? Unearned income includes but is not limited to, Contributions, Social Security, SSI, VA, Child Support, Unemployment, Retirement, or any other income.

☐ Yes ☐ No

If yes, complete the information below and provide proof of all income received in the last 30 days.

Name	Source	Amount	How Often?



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**LOTTERY AND GAMBLING WINNINGS**

Has anyone won substantial lottery or gambling winnings of at least \$4,500 or above? Yes \_\_\_\_ No \_\_\_\_

If so, who? \_\_\_\_\_ When? \_\_\_\_\_ Amount? \_\_\_\_\_

**CHILD SUPPORT PAYMENTS**

Are you or someone in your household obligated to pay child support to someone living outside of the home?  
Yes \_\_\_\_ No \_\_\_\_

Who is obligated to pay? \_\_\_\_\_

How much is the obligated amount? \_\_\_\_\_

For whom is the child support paid? \_\_\_\_\_

To whom is child support paid? \_\_\_\_\_

How often is child support paid? \_\_\_\_\_

How much is the actual amount paid? \_\_\_\_\_

**RESOURCES**

Has anyone in your household had a change in resources? Yes \_\_\_\_ No \_\_\_\_

If yes, complete chart below.

Resource Type	Owner	Amount/Value	Bank Name
Cash			
Checking/Savings			
Credit Union			
Stocks or Bonds			
Safe Deposit Box			

**SNAP Penalties**

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- Do not give false information or hide information to get benefits that your household should not get.
- Do not use SNAP or EBT cards that are not yours and do not let someone else use yours.
- Do not use SNAP benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell SNAP or EBT cards for illegal items, such as firearms, ammunition, or controlled substance (illegal drugs).

Any household member who breaks any of the SNAP rules on purpose can be barred from SNAP for one year to permanently, fined up to \$250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from SNAP for an additional 18 months if court-ordered.



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I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to SNAP requirements. I will also report if anyone in my household receives lottery or gambling winnings, in the gross amount of \$4500 or more (before taxes or other amounts are withheld). I will report these winnings no later than 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my periodic report and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**VOTER REGISTRATION INFORMATION**

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

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ I do not want to answer the Voter Registration question

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 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.

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 State at: 2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

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

**A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.**



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**(Keep this document for your information)**

**Notice of ADA/Section 504 Rights**

**Help for People with Disabilities**

The Georgia Department of Human Services ("the Department") is required by federal law\* to provide persons with disabilities an equal opportunity to participate in and qualify for the Department's programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Department provides reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities, communication assistance, such as sign language interpreters. Our help is free. The Department is not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

**How to Request a Reasonable Modification or Communication Assistance**

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (877) 423-4746 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at <https://dfcs.georgia.gov/adasection-504-and-civil-rights>, but you do not have to use a form to make a request.

**How to File a Complaint**

You have the right to make a complaint if the Department has discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights and ADA/Section 504 Coordinator at 47 Trinity Avenue, SW, Atlanta, GA 30334, (877) 423-4746.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at <https://dfcs.georgia.gov/adasection-504-and-civil-rights>. If you need help making a discrimination complaint, you may contact any DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "Nondiscrimination Statement".

*\*Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*





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**Do Not Send Applications to the USDA**

**Nondiscrimination Statement**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620- 1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

- 1. mail:**  
Food and Nutrition Service, USDA  
1320 Braddock Place, Room 334  
Alexandria, VA 22314; or
- 2. fax:**  
(833) 256-1665 or (202) 690-7442; or
- 3. email:**  
[FNCSIVILRIGHTSCOMPLAINTS@usda.gov](mailto:FNCSIVILRIGHTSCOMPLAINTS@usda.gov)

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights and ADA/Section 504 Coordinator at 47 Trinity Ave. SW, Atlanta, GA 30334, 877-423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, or call (877) 423-4746.

**Do Not Send Applications to the USDA**