

# Combined Six-Month Report

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- Answer all questions the best you can.
- Return the form and proofs right away.
- Sign and date the form before returning.
- Call your worker if you have questions.

## 1. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	PHONE NUMBER	
STREET ADDRESS		CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (if different)		CITY	STATE	ZIP CODE	COUNTY

## 2. Has anyone moved in or out of your home in the past six months?

No  Yes – fill in below

<b>PERSON 1</b>	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO YOU	
MOVED IN OR OUT?		DATE OF CHANGE		U.S. CITIZEN OR U.S. NATIONAL?	ETHNICITY (optional)	RACE (optional)*
<input type="radio"/> Moved in <input type="radio"/> Moved out				<input type="radio"/> Yes <input type="radio"/> No	Hispanic? <input type="radio"/> Yes <input type="radio"/> No	
<b>PERSON 2</b>	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO YOU	
MOVED IN OR OUT?		DATE OF CHANGE		U.S. CITIZEN OR U.S. NATIONAL?	ETHNICITY (optional)	RACE (optional)*
<input type="radio"/> Moved in <input type="radio"/> Moved out				<input type="radio"/> Yes <input type="radio"/> No	Hispanic? <input type="radio"/> Yes <input type="radio"/> No	

\*Race Codes: (choose all that apply)

**A** – Asian **B** – Black/African American **N** – American Indian/Native Alaskan **P** – Pacific Islander or Native Hawaiian **W** – White

## 3. Is anyone getting health care coverage through Medical Assistance (MA) or benefits from a Medicare Savings Program?

No – go to question 14  Yes – go to question 4

**4. Do you want to apply for someone who is not getting coverage now?**

No  Yes – fill in below

First name	MI	Last name	Sex	Marital status	Social Security number**
			<input type="radio"/> M <input type="radio"/> F		
			<input type="radio"/> M <input type="radio"/> F		

\*\*See the end of this form for information about how your Social Security number may be used.

**5. Is anyone self-employed or does anyone expect to be self-employed?**

No  Yes – fill in below and send proof. Proof can be a copy of your most recent income tax returns.

Name	Business name	Start date	Yearly income
			\$
			\$

**6. Does anyone work or does anyone expect to start working?**

Include temporary and seasonal work.

No  Yes – fill in below and send proof. Proof can be copies of paystubs from the last 30 days.

Name	Employer name	Start date	Is this job seasonal?	Amount received (include tips)	How often paid?
			<input type="radio"/> No <input type="radio"/> Yes	\$	
			<input type="radio"/> No <input type="radio"/> Yes	\$	

**7. Does anyone get money or does anyone expect to get money from sources other than work?**

- Include:
- Social Security
  - Veterans' benefits
  - Trusts
  - Supplemental Security Income (SSI)
  - Retirement or pension
  - Interest or dividends
  - Child or spousal support
  - Public assistance
  - Contract for deed
  - Unemployment
  - Rental income
  - Any other payments
  - Workers' compensation
  - Annuities

No  Yes – fill in below and send proof. Proof can be copies of checks or benefit statements from the last 30 days.

Name	Type of income	Start date	Amount	How often received
			\$	
			\$	
			\$	
			\$	

**8. Is anyone 21 or older enrolled in or applying for Medical Assistance (MA) or a Medicare Savings Program?**

No – go to question 13  Yes – answer questions 9–12



**14. Does your household get help through the Supplemental Nutrition Assistance Program (SNAP) to buy food with your Electronic Benefit Transfer (EBT) card?**

No – go to page 5 to sign and date this form.  Yes – answer questions 15–18

**15. Has your household moved since your last application or in the past six months?**

No  Yes – if you have not already reported the change to your worker, fill in below and send proof of rent or mortgage payment. Proof can be a copy of a payment receipt or payment notice.

NEW RENT OR MORTGAGE PAYMENT \$	CHECK THE UTILITIES YOU PAY: <input type="checkbox"/> Heat/Air Conditioning <input type="checkbox"/> Electricity <input type="checkbox"/> Telephone
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**16. Since your last application or in the past six months, has anyone had a change in their income from work such as salary or hourly rate of pay, source of income, starting, stopping or changing jobs, employment status from full-time or part-time?**

Include self-employment.

No  Yes – if you have not already reported the change to your worker, fill in below and send proof. Proof can be copies of paystubs or most recent income tax returns if self-employed.

Name	Employer or business name	Start or end date	Amount received	How often paid?	Hours worked
			\$		
			\$		

**17. Since your last application or in the past six months, has anyone had a change of more than \$50 per month from income sources other than work or a change in a source of unearned income?**

No  Yes – if you have not already reported the change to your worker, fill in below and send proof. Proof can be copies of checks or benefit statements.

Name	Type and source of income	Start or end date	Amount	How often received
			\$	
			\$	

**18. Since your last application or in the past six months, has anyone had a change in court-ordered child or medical support payments?**

No  Yes – if you have not already reported the change to your worker, fill in below and send proof. Proof can be a copy of the court order.

NAME OF PERSON PAYING	MONTHLY AMOUNT \$	CURRENTLY PAYING? <input type="radio"/> No <input type="radio"/> Yes
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**If you are an able-bodied adult without dependents who receives SNAP, answer the following question.**

**19. Did you work 20 hours each week, for an average of 80 hours each month during the past six months?**

No  Yes

## Sign and date this form and return it to your county agency.

### This is important information you must read before signing.

I understand that my benefits may stop, be reduced or change because of the information I give on this form. I understand that changes may be made to my benefits without 10 days advance notice. However, a written notice will be sent to me no later than the effective date of change.

### Telling the Truth

I declare that, under penalty of perjury, all parts of this form are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to \$10,000, or both.

YOUR SIGNATURE		DATE
SIGNATURE OF PERSON ACTING ON YOUR BEHALF (AUTHORIZED REPRESENTATIVE)	PHONE NUMBER	DATE

## Social Security numbers

You must provide a Social Security number (SSN) for each household member applying for benefits. (Food Stamp Act of 1977 as amended by PL 97-98 and the Social Security Act of 1935 [section 1137] as amended by PL 98-369)

If you need an SSN we can help you apply for one. The state uses your SSN:

- To check identity, prevent duplicate participation and to make mass changes.
- To determine eligibility and benefit levels for programs such as SNAP, family cash assistance, health care programs and the school lunch program.
- For program reviews and audits to determine household eligibility, including fraud investigations.
- To coordinate with other programs or state agencies to provide more effective and meaningful services to you.

If you are not a U.S. citizen and are applying for emergency health care coverage only, you do not have to provide an SSN.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ደኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዩን ስራተኛ ይጠይቁ ወይም በስልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲန့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်တကျိးထံဝဲဒၣ်လၢ် တီလၢ်စိတခါအံၤန့ၢ်,သံကွၢ်ဘဉ်ပုၤဂ့ၢ်ဝိအပုၤမၤစၢၤတၢ်လၢန့ၢ်မ့တ မ့ၢ်ကိးဘဉ် 1-844-217-3549 တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໂທ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

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For accessible formats of this information or assistance with additional equal access to human services, write to DHS.Info@state.mn.us, call 800-657-3739, or use your preferred relay service.