LDSS-4310 (Rev. 8/02)

LDSS

Periodic Report

ADDRESS
CITY, STATE ZIP

You must fill out this Report and return it to the address listed on the back by **REPORT DUE DATE** to continue getting benefits.

WHEN YOU RETURN THIS REPORT, MAKE SURE THAT THE **LOCAL DISTRICT ADDRESS ON THE BACK** OF THIS REPORT SHOWS IN THE RETURN ENVELOPE WINDOW.

CASE NAME
ADDRESS
CITY, STATE ZIP

This "Periodic Report" is a new report form that replaced the one called "Quarterly Report". Like the Quarterly Report some of your benefits could be discontinued if you fail to complete, sign and return this Periodic Report by it's due date. The new Periodic Report is simpler and has less questions than the Quarterly Report but still gathers all information about changes you may have had since the last time you were in contact with the eligibility worker. As this is new, please read and follow the instructions for this Periodic Report.

CASE NAME **CASE NAME**		CASE NUMBER **CASE NUMBER**
OFFICE **OFFICE**	UNIT **UNIT**	WORKER **WORKER**
If you have any questions on how to fill out this Report, call:**( ) PHONE NUMBER**	We must get your completed Report by **REPORT DUE DATE**. If we don't get the completed Report by this date, your benefits will stop.	

General Instructions

1. You must **answer all questions** on this Report. Answer all questions on this Report for everyone who is getting, **or** anyone who is legally responsible for someone getting, Temporary Assistance, Child Care, Medicaid and/or Food Stamp Benefits.
2. Do **not** sign this Report any sooner than **SIGNATURE DATE.** If you do, this report is not considered complete.
3. You must complete this Report and return it to the address on the back of this report by **REPORT DUE DATE**, or your Temporary Assistance, Medicaid, Child Care or Food Stamp Benefits may be reduced or closed.

Reminder: For **Temporary Assistance and Medicaid,** you must report any changes to your worker within 10 days. For **Food Stamp Benefits,** you must report within ten days after the end of the month if your total monthly gross income exceeds the 130% limit you have been given. Otherwise, you do not need to report changes at any time other than on this Periodic Report or at Recertification, whichever occurs first. You must contact your worker immediately if any changes occur that affect your **Child Care**.

LDSS-4310 (Rev. 8/02)

SECTION 1: Please list ALL income for EACH household member

(Examples of income include earnings from a job, Unemployment Insurance, Social Security Benefits, Supplemental Security Income [SSI])

Who	Name of Employer or Other Source of Income	How Often? (Daily, Weekly, Bi-Weekly, Monthly)	Total # of Hours Worked Per Week **REPORT MONTH**

Send in proof of all income that any household member got during the entire month of REPORT MONTH.

If CAP INDICATOR IS PRESENT, THE FOLLOWING SENTENCE WILL REPLACE THE SENTENCE ABOVE:

Since you participate in the Child Assistance Program (CAP), send proof of earnings, other income, and child care costs for 1ST Month of Report Qtr, 2ND Month of Report Qtr, and **3RD Month of Report Qtr.**

SECTION 2: Have there been any other changes (read boxes below) since your last Report, or do you expect any changes?

No ☐ or Yes ☐ **If Yes, you must check (√) at least one of the boxes below.**

☐ Your household moved (Write the new address below.)
☐ Someone moved into or out of your household (Write who moved and when and new amount of rent.)
☐ Your rent went up or down (Write new rent amount.)
☐ Someone started or left work (Write who, when, and where they started or left work.)
☐ Your child care costs or child care provider changed (Write new amount and who provides the child care.)
☐ Your need for child care has changed due to a change in your work schedule or other reason. (Explain what has changed)
☐ A change in contribution or subsidy (Write what the contribution is and new amount.)
☐ Someone is pregnant (Write who and expected delivery date, if known.)
☐ Death or Birth of someone in the household (Write who and when.)
☐ Change in legally obligated child support paid by a member of your household (Write who in your household pays the support.)
☐ Other changes that may affect benefits (Write who, what, and when change occurred and give proof, if possible.)

Write the details of your change(s) here, and if you have proof send it in:

_____

_____

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Temporary Assistance Benefits, Food Stamp Benefits, Child Care Benefits, and Medicaid or closing my case. I am aware that Federal and State Law provide for fine and/or imprisonment of any person who fraudulently attempts to receive, or fraudulently receives Temporary Assistance, Medicaid, Child Care or Food Stamp Benefits to which the person is not entitled.

I understand that I must contact my worker to report any changes that occur for my Temporary Assistance case within 10 days.

I understand that I must contact my worker immediately if any changes occur that affects my child care. I also understand that if I use a child care provider who is not licensed or registered, my provider must meet certain requirements in order to be paid.

For my Food Stamp Benefits case, I must report changes on the Periodic Report and at Recertification, whichever occurs first. I may also report changes at any other time.

IMPORTANT- YOU MUST SIGN AND DATE THIS FORM NO SOONER THAN SIGNATURE DATE. IF YOU CHECKED "YES" TO ANY CHANGES IN SECTION 2, MAKE SURE YOU CHECKED (√) THE BOX(ES) AND GAVE MORE DETAIL. IF THIS REPORT IS NOT COMPLETE, WE WILL SEND YOU A DISCONTINUANCE NOTICE.

Your Signature:	Date:	Telephone Number (daytime)

Fill Out & Return In The Envelope Provided

When you return this Report, make sure you can see this address in the return envelope window ➔

LDSS
OFF/UNIT/WKR
ADDRESS
ADDRESS
CITY, STATE ZIP