



DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
 Ran-Care Commercial Bldg, CBU #207, 761 S. Marine Corps Drive, Tamuning, Guam 96913
 Northern (671) 635-7432/7485 / Central (671) 300-8853/8863 / Southern (671) 828-7542

SNAP – Periodic Change Report (PCR)

Case Name and Mailing Address:		
Center	Case Number	ES Code

Caution: Do not return this form before the first day of the month listed above. We will return the form to you if you send it in early.

Your benefits will stop if you do not complete and return the form by the 10th of the month this form is due.

Please COMPLETE form and READ, SIGN and DATE (Page 3).

THIS IS NOT AN APPLICATION FORM FOR SNAP. (Supplemental Nutrition Assistance Program)

TO CONTINUE YOUR BENEFITS, RETURN THIS BY THE 10TH OF: _____

- You **must** turn this form to get benefits.
- Answer the questions for yourself and all persons living with you for: _____ (Enter the 5th month for last application date)
- Attach a sheet of paper if you need more room.
- **ATTACH PROOF** of what you report.

Your benefits may get delayed if:

- You return this form after the 10th of the month, or
- It is incomplete.

HOW TO USE THIS FORM

This form is needed to show that you are still eligible for SNAP benefits. Answer **all** questions about who live with you. Give **all** household income from **all** sources. This includes **earned** and **unearned** income for **all** household members.

ANSWER ALL QUESTIONS. BE SURE TO SIGN AND DATE ON THE BACK OF THE FORM.

By signing this form, I understand and agree to the following conditions:

- ⇒ I **MUST** return this form to get benefits. I **MUST** wait until the return date at the top of this form to be sure I have reported **all** information.
- ⇒ I can talk to an Eligibility Specialist or a person in charge if I have questions about this form.
- ⇒ I will report all people living in my home whether they receive Food Stamp/SNAP benefits or not.
- ⇒ If I quit a job without a good reason, I may lose Food Stamp/SNAP for doing any of the following:

Offense	The penalty is loss of benefits:
<ul style="list-style-type: none"> • Hiding information or making false statements • Using EBT cards that belong to someone else • Using SNAP benefits to buy alcohol or tobacco • Trading or selling SNAP benefits or EBT cards 	<ul style="list-style-type: none"> • 12 months for the first offense • 24 months the second offense • Permanently for the third offense
<ul style="list-style-type: none"> • Trading SNAP benefits for controlled substances such as drugs 	<ul style="list-style-type: none"> • 24 months for the first offense, permanently for the second time
<ul style="list-style-type: none"> • Trading SNAP benefits for firearms, ammunition or explosives 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Trading, buying, or selling SNAP benefits of \$500 or more 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Anyone misrepresenting his/her IDENTITY or RESIDENCE in order to receive multiple benefits 	<ul style="list-style-type: none"> • Ineligible to participate in the program for 10 YEARS
If you knowingly do the following	You may be
<ul style="list-style-type: none"> • Use an EBT card which is not yours • Transfer your EBT card to other people • Acquired or possess EBT card which are not yours 	<ul style="list-style-type: none"> • Guilty of a felony or misdemeanor • Fined • Put in prison • Ineligible for food benefits for a period of time

USDA Nondiscrimination Statement: In accordance with federal civil rights laws 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, audiotope, 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:** FNSCIVILRIGHTSCOMPLAINTS@USDA.GOV

This institution is an equal opportunity provider.

1) RESIDENCE: Our records show that you live at: **Answer the questions for (Report month):** _____
(Enter the 5th month from last application date).

Do you still live at this address? YES, go to (2) NO, please complete below.

Home Address	City	State	Phone Number(s)
Mailing Address	City	State	Phone Number(s)
Do you pay for housing?	<input type="checkbox"/> if YES, complete below <input type="checkbox"/> NO		
		Rent: \$	Mortgage (if buying) \$

Amount you pay monthly? \$ Insurance per year? \$ Property tax, If separate: \$ Per year: \$

Check all utilities you pay for:	<input type="checkbox"/> Power \$ _____	<input type="checkbox"/> Kerosene (Gas)/Cooking Fuel \$ _____	<input type="checkbox"/> Water \$ _____
	<input type="checkbox"/> Sewer \$ _____	<input type="checkbox"/> Trash \$ _____	<input type="checkbox"/> Telephone (Landline or Contract Only) \$ _____

2) Who lives at this address with you? (List each person living in your home.)

NAME (Last, First, Middle)	Relationship to you	Gender (Circle One)		Date of Birth	Wants SNAP? (Circle One)		Purchase and prepare meals with you? (circle one)	
		M	F		Y	N	Y	N
	Self	M	F		Y	N	Y	N
		M	F		Y	N	Y	N
		M	F		Y	N	Y	N
		M	F		Y	N	Y	N
		M	F		Y	N	Y	N
		M	F		Y	N	Y	N

Are you or anyone living with you a student? YES NO

If yes, who? _____

Name of school? _____

3) Paying Child Support

If anyone living with you is court-ordered to pay child support, has the court order changed? YES NO

4) Does anyone work? If yes, complete below. YES NO

List each job for each person who works. Attach proof (PAY STUBS) for the income you received in the report month.

If you are self-employed, check here <input type="checkbox"/>	JOB #1	JOB #2	JOB #3
Person Working			
Employer's Name and Phone Number			
Job Title			
Hourly Pay	\$	\$	\$
Hours per Week			
How often are you paid? (Weekly/Bi-Weekly/Bi-Monthly/Monthly)	\$	\$	\$
Tips, overtime, bonuses, or commission? (Please circle those which apply)			
Will this income continue	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
New amount?	\$	\$	\$
Date of change?			
If you are not paid by the hour, explain your income here:			
If your income will change, give the reason for the change here:			

5) Does anyone get money from any other source? YES NO

(If YES, complete below. Attach proof.) Some examples are:

- Social Security
 Veterans Benefits
 Student Income/Money for school
 Loans/Gifts
 Interest Income
 Worker's Compensation
 Child Support
 Winnings

Name of Person Who Got Other Money	Source of Other Income	How Often Paid?	Amount of Each Payment?	Amount This Month?	Will This Income Continue?

If the income will change, give the new amount. What is the reason for the change and when will it change?

PENALTY WARNING

Failure to report such changes may result in an under-issuance of SNAP (Food Stamp) and/or Cash benefits for which you will not be reimbursed or an over-issuance of SNAP and/or Cash benefits that you must pay back, or your case may be closed due to Intentional Program Violation (IPV). If you are found guilty of IPV under the SNAP and/or Cash programs, you will be disqualified for one (1) year for the first violation, two (2) years for the second violation, and permanently for the third violation. Any household member who intentionally breaks SNAP rules can be fined up to \$250,000, imprisoned up to twenty (20) years or both. For the Medically Indigent Program (MIP), if you fail to report information that would have made you ineligible, you will be disqualified for three (3) months for the first violation; six (6) months for the second and subsequent violations.

READ and SIGN: The information I give on this form is true and complete. I have read all pages of this form and understand it. I agree to the conditions on page 1.

Signature of Person Completing this Form: _____ Phone Number: _____ Date: _____