**REQUEST FOR INFORMATION**

ES-3105.1

07-12

|  |  |
| --- | --- |
| To:  Address:              | Case Number:      Date:        |

We need the following information to determine/redetermine your eligibility for

[ ]  Cash [ ]  Food [ ]  Medical [ ]  Child Care assistance.

**The items checked below must be provided no later than** or your**.**

**Please return a copy of this form when sending your verifications.**

|  |  |
| --- | --- |
| **Income and Resources**[ ]  Paychecks received by       for the months of      [ ]  A signed statement from       employer showing gross earnings, number of hours worked, how much paid per hour, and dates paid for the month(s) of:      [ ]  Proof of self-employment income and expenses for the month(s) of      [ ]  A benefit letter or other proof from       that shows the monthly gross income for each member of your household that receives it.[ ]  Proof of child support and alimony received in the  month(s) of       including county and court order number.[ ]  Proof of saving, checking, and/or debit account balance(s).**Expenses****[ ]** Proof of child or dependent care expenses.[ ]  Proof of child support paid in the month(s) of including county and court order number.[ ]  Medical bills for the month(s) of            **Citizenship and Identification****[ ]** Proof of citizenship or alien status for      [ ]  Birth verification and one other piece of identification for       [ ]  Social Security Number (SSN) and/or proof of applying for a SSN for             | **Medical****[ ]** Verification of life and/or burial insurance, including policy name, number, year of issue, face value, and current cash surrender value for each policy. [ ]  Health insurance card or copy of front and back of card.**Child Care****[ ]**  Daily schedule of child care needed for each child.  (use agency form if attached.)[ ]  Name of DCF child care provider selected.[ ]  Copy of work schedule for      [ ]  School schedule for each child.**TANF/Cash and work programs****[ ]**  Appointment with       Date:       Time:       Location:      [ ]  Proof of unemployment application for      [ ]  Proof of school enrollment for      **Other****[ ]** **[ ]** Doctor’s statement for       including the nature of the disability and length of time  unable to work. (Use agency form if attached.)[ ]  Complete application/review form.[ ]  We will call you for an interview on      at       (Date) (Time) at phone number      [ ]  Complete PMDT Packet/Questionnaire. |

If you have any questions or if you need assistance in obtaining any of this information, call

at

Local Office: