**REQUEST FOR INFORMATION**

ES-3105.1

07-12

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| 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: