Public Assistance and Food Stamp Program

Orientation Booklet

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Department of Public Health and Social Services
Division of Public Welfare
Bureau of Economic Security Administration

October 1988

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Page No.

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF ECONOMIC SECURITY

I. MISSION STATEMENT

families so they may live their lives with dignity and respect.

As a Bureau, we do the following:

- Provide the basic essentials of food and financial assistance to needy individuals and families so they may be assured a minimum standard of living, and

- Foster economic independence by helping and encouraging those who are able to leave the public assistance rolls to become self-sufficient.

STATEMENT OF PHILOSOPHY

trusted us with responsibilities that we will strive to perform at an optimum level.

- We value the worth, dignity, and rights of our clients.

- We value services delivered in a manner which promotes self-sufficiency, independence and responsibility.

- We value public relations and education programs as a means of developing public understanding. Feedback from the community, including complaints, will be considered.

- We value our responsibility as active members of the Department. As a Bureau, we want to be respected and recognized by the Department as a resource of innovative social service approaches.

II. PUBLIC ASSISTANT PROGRAMS

STATUTORY BASE

Bureau of Economic Security administers financial assistance programs for needy persons authorized under the Government Code of Guam, Title X, and the Federal Social Security Act under the following titles:

Title I - Old Age Assistance

Blind

he Permanently and
Disabled

Title IV-A - Aid to Families with Dependent Children

In addition, BES administers the Indo-Chinese Refugee Assistance Program (IRAP) and the General Assistance Program (GA).

OLD AGE ASSISTANCE PROGRAM

TITLE I
OLD AGE ASSISTANCE
(OAA)

Basic Eligibility

To be eligible for aid, and individual must meet the following criteria:

Age: 65 years or older, and needy.

Social Security Number must be furnished, or a receipt that they applied for one;

Citizenship: U.S. or alien admitted for permanent residence; if less than 3 years date of entry, sponsor and spouse's income and resources are considered;

Resources: Maximum limit of $1,000 personal property. The value of a home owned and occupied by the applicant is excluded, and the value of a car up to $1,500. One burial plot is also excluded and the equity value of a funeral agreement up to $1,500.

Income: Gross income wages, VA benefits, retirement income, social security benefits and contributions must not exceed the standard for basic need, including allowances provided for rental and utilities for onemember:

Needs	$60.00	
Rental		60.00
Power		10.00
Water		5.00
Fuel		5.50
Telephone		4.50
		$145.00

AID TO THE BLIND

TITLE X
AID TO THE BLIND

To be eligible for aid, an individual is considered blind if he has central visual acuity of 20/200 or less in the better eye with correcting glasses, or a field defect in which the periheral field has contacted to such extent that the widest diameter of visual field subtends an angular distance of no greater than 20°.

Age: 18 years of age or older.

Social Security Number must be furnished, or a receipt that they applied for one.

Citizenship: U.S. or alien admitted for permanent residence; if less than 3 years date of entry, sponsor and sponsor's spouse's income and resources are considered.

Resources: Maximum limit of $1,000 personal property. The value of a home owned and occupied by the applicant is excluded, and the value of a car up to $1,500. One burial plot is also excluded and the equity value of a funeral agreement up to $1,500.

Income: Gross income wages, VA benefits, retirement income, social security benefits and contributions must not exceed the standard for basic need, including allowances provided for rental and utilities for one member:

Need	$ 60.00
Rental	60.00
Power	10.00
Water	5.00
Fuel	5.50
Telephone	4.50
	$145.00

AID TO FAMILIES WITH DEPENDENT CHILDREN

TITLE IV - A
AID TO FAMILIES WITH DEPENDENT CHILDREN
(AFDC)

Basic Eligibility

To be eligible for aid, children deprived of support and care by reason of:

- continued absence of parent(s)
- medical incapacity of parent(s)
- unemployed parents
- death of parent(s)

may receive assistance, provided the following criteria are met:

Age: Children under 18 years who are full-time students, and reasonably expected to complete a program of secondary school before reaching age 19;

Social Security Numbers must be furnished for each person in the household, or a receipt that they applied for one;

Citizenship: U.S. or alien permitted for permanent residence; if less than 3 years from date of entry, sponsor and sponsor's spouse's income and resources are considered;

Resources: Maximum limit of $1,000 personal property. The value of a home owned and occupied by a member of the assistance unit is excluded, and the value of a car up to $1,500. One burial plot is also excluded and the equity value of a funeral agreement up to $1,500.

Income: Gross income must not exceed 185% of the standard need for basic needs including allowances provided for rental and utilities.

Need	$ 60.00
Rental	60.00
Power	10.00
Water	5.00
Fuel	5.50
Telephone	4.50
	$145.00

AID TO THE PERMANENTLY AND TOTALLY DISABLED

[redacted]

To be eligible for aid, a person's disability or combination of disabilities shall be permanent and total to substantially prevent a person from engaging in a useful occupation with his competence, such as gainful employment or homemaking.

"Permanently" is related to the duration of the impairments or combination of impairments. "Totally" is related to the degree of disability.

Age: 18 years of age or older.

Social Security Number must be furnish, or a receipt that they applied for one.

Citizenship: U.S. or alien admitted for permanent residence; if less than 3 years date of entry, sponsor and sponsor's spouse's income and resources are considered.

Resources: Maximum limit of $1,000 personal property. The value of a home owned and occupied by an applicant is excluded, and the value of a car up to $1,500. One burial plot is also excluded and the equity value of a funeral agreement up to $1,500.

Income: Gross income wages, VA benefits, retirement income, social security benefits and contributions must not exceed the standard for basic need, including allowances provided for rental and utilities for one member:

Need	$ 60.00
Rental	60.00
Power	10.00
Water	5.00
Fuel	5.50
Telephone	4.50
	$145.00

GENERAL ASSISTANCE

GENERAL ASSISTANCE (GA)

Basic Eligibility

To be eligible for aid, and individual must not have met the criteria for the other public assistance programs, i.e. OAA, AB, APTD, AND AFDC.

Age: 18 years of age or older.

Social Security Number must be furnished, or a receipt that they applied for one.

Citizenship: U.S. or alien admitted for permanent residence; if less than 3 years date of entry, sponsor and sponsor's spouse's income and resources are considered.

Resources: Maximum limit of $1,000 personal property. The value of a home owned and occupied by the applicant is excluded, and the value of a car up to $1,500. One burial plot is also excluded and the equity value of a funeral agreement up to $1,500.

Income: No source of income.

Need	$ 60.00
Rental	60.00
Power	10.00
Water	5.00
Fuel	5.50
Telephone	4.50
	$145.00

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
Post Office Box 2816
Agana, Guam 96910

REFERRAL FOR WIN REGISTRATION

NOTICE TO AFDC APPLICANTS AND RECIPIENTS

[redacted]

may withdraw from the WIN program at any time without penalty as long as he or she continues to be exempt from the WIN registration requirement.

In order to register, you must take this form with you and report to the following WIN Office:

Room Number _____ Number _____ Street _____

City _____ State _____ Zip Code _____

Date of Appointment: _____ If you are unable to appear, please call _____.

---

1. NAME _____ 2. CASE NAME _____

3. ADDRESS _____ 4. CASE NO. _____
Number Street Apt.

_____ 5. SOCIAL SECURITY NUMBER _____
City State Zip Code

6. TELEPHONE

7. a. AFDC Status: 1) AFDC Applicant Mandatory ☐ Voluntary ☐
2) AFDC Recipient Mandatory ☐ Voluntary ☐
b. AFDC-UF: Yes ☐ No ☐

8. COMMENTS: _____

_____

_____

9. Name of IM Worker _____ 10. Address of IM Office _____

11. Telephone _____ _____

12. Date of Referral _____ _____

GUAM
DIVISION OF PUBLIC WELFARE
ASSISTANCE PAYMENT UNIT

ASSIGNMENT OF SUPPORT

I, _____ hereby assign to the Department of Public Health and Social
(NEEDY CARETAKER) Services my right to receive child support

FROM:

ast First Middle)	NAME OF ABSENT PARENT (Last First Middle)	COURT ORDER NO.

This Assignment is for the full amount of court ordered child support payments which have accrued and are accruing, prior to and during the period of my receiving public assistance whether paid before or after termination of assistance in accordance with Public Law 93-647. I understand that such court ordered payments will be paid directly to the Division of Social Services for so long as I may receive welfare assistance.

In the event that no child support court order presently exists, this Assignment entitles the Division of Social Services to receive any child support payments obtained through a future court order. I also agree to turn over to the Division of Social Services any money the absent parent gives or has given to me for my children.

I also understand that my failure to sign this form and assign my rights to child support will result in my being ineligible for public assistance and the Department will remove my benefits from the budget and my child's/children's check will be paid to someone else as a protective payment.

Signed: _____

Address: _____

Phone No. _____

Date: _____

_____
APU WORKER'S SIGNATURE

TO CHILD SUPPORT UNIT

12/78

GUAM
DIVISION OF PUBLIC WELFARE
ASSISTANCE PAYMENT UNIT

CLIENT OBJECTS ☐ "BEST INTEREST OF CHILD" EXCEPTION

1. LOCATION INFORMATION ON ABSENT PARENTS
2. BASIC INFORMATION ON INTACT FAMILIES

I. INFORMATION ON PAYEE (PERSON APPLYING FOR OR RECEIVING AFDC)

NAME	MAIDEN NAME	ADDRESS

III. PRESENT MARITAL STATUS OF NATURAL PARENTS TO EACH OTHER (CHECK ONE, COMPLETE ALL INFO. REQUESTED)

a. ☐ Still married living together.
b. ☐ Divorced, Date ___/___/___ Support Order No. _____
Name and Address of Court: _____
c. ☐ Legally Separated. Date ___/___/___ Support Order No. _____
Name and Address of Court: _____
d. ☐ Are you currently receiving direct support from your divorced or separated spouse. ☐YES ☐NO Amount_____ through court _____ direct. ____
e. ☐ Mutually Separated. Date ___/___/___ Place _____ Have you started divorce action? ☐YES ☐NO
f. ☐ Not married to absent parent. Has paternity of minor child(ren) been established in court ☐YES ☐NO Support Order No. _____ $_____ AMT. OF SUPPORT
g. ☐ Deserted. Date ___/___/___ Place _____
h. ☐ Deceased. Date ___/___/___ Place _____
i. ☐ Other (e.g. one spouse told to leave home by other spouse) Date, Place, City & State _____

IV. INFORMATION ON ABSENT PARENT (USE SEPARATE FORM FOR EACH ABSENT PARENT THAT CORRESPONDS WITH THE CHILDREN LISTED IN SECTION II.

FULL NAME	ALIAS				SEX-IF FEMALE, MAIDEN NAME ☐M ☐F
PRESENT ADDRESS	LAST KNOWN ADDRESS				DATE ___/___/___
SOCIAL SECURITY NO	DATE OF BIRTH ___/___/___	PLACE OF BIRTH	MAKE/YEAR OF CAR		VEHICLE LICENSE NO
LAST KNOWN EMPLOYER & ADDRESS			DATE OF LAST EMPLOYMENT-TELEPHONE ___/___/___		
DESCRIPTION HEIGHT	WEIGHT	COLOR HAIR	COLOR EYES	RACIAL BACKGROUND	SCARS, MARKS, TATTOOS, DESCRIBE
					GLASSES ☐YES ☐NO
					ATTACH LATEST PHOTO OF ABSENT PARENT
MILITARY SERVICE ☐PAST ☐PRESENT					
NAME AND ADDRESS OF FOLLOWING ABSENT PARENT'S MOTHER					
ABSENT PARENT'S FATHER					
ABSENT PARENT'S BROTHER					
ABSENT PARENT'S SISTER					
ABSENT PARENT'S FRIENDS					
ORGANIZATION AFFILIATIONS	UNIONS	CLUBS			

V. Location statement. I have been informed of the Child Support Enforcement Program, and I understand that I must cooperate in the location of the Absent Parent. I am aware that if I do not cooperate I may be removed from assistance. I have been informed of the "Best Interest of The Child Exception"

BES-030 8/87

Signed _____ _____ Date _____

TO CHILD SUPPORT ENFORCEMENT UNIT

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICE
GOVERNMENT OF GUAM CENTER
P.O. BOX 2816
AGANA, GUAM

FIRST NOTICE OF REQUIREMENT TO COOPERATE AND RIGHT TO CLAIM GOOD CAUSE FOR REFUSAL TO COOPERATE IN CHILD SUPPORT ENFORCEMENT:

BENEFITS OF CHILD SUPPORT ENFORCEMENT:

ild support enforcement process may be of value to you and your child because it might
efits:
ent;
ur child's paternity;
pport payments might be higher than your welfare grant; and
u and your children may obtain rights to future social security, veterans, or other government benefits.

WHAT IS MEANT BY COOPERATION?

The law requires you to cooperate with the welfare and child support agencies to get any support owed to you and any of the children for whom you want AFDC, unless you have good cause for not cooperating.

In cooperation with the welfare or child support agency, you may be asked to do one or more of the following things:

* Name the parent of any child applying for or receiving AFDC, and give information you have to help find the parent;
* Help determine legally who the father is if your child was born out of wedlock;
* Give help to obtain money owed to you or the children receiving AFDC; and
* Pay to the State any money which is given directly to you by the absent parent (you will continue to get your full AFDC grant from the State).

You may be required to come to the welfare office, child support office, or court to sign papers or give necessary information.

WHAT IS MEANT BY GOOD CAUSE?

You may have good cause not to cooperate in the State's efforts to collect child support. You may excused from cooperation if you believe that cooperation would not be in the best interest of your child, and if you can provide evidence to support this claim.

IF YOU DO NOT COOPERATE AND YOU DO NOT HAVE GOOD CAUSE:

* You will be ineligible for AFDC.
* Your children will still be eligible for AFDC for their own needs. Your children's grant will go to another person, called a "protective payee".

AND WHEN YOU MAY CLAIM GOOD CAUSE:

* If you want to claim good cause, you must tell a worker that you think you have good cause. You can do this at any time you believe you have good cause not to cooperate.
* If you claim "good cause" you must be given another notice. This will explain the circumstances under which the Welfare Agency may find good cause, and the type of evidence or other information the Welfare Agency needs to decide your claim. You may also ask for this second notice to help you decide whether or not to claim good cause.

I have read this notice concerning my right to claim good cause for refusing to cooperate:

_____ _____
SIGNATURE OF APPLICANT/RECIPIENT DATE

I have provided the applicant/recipient with a copy of this notice.

_____ _____
SIGNATURE OF WORKER DATE

BES-026 8/87

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
GOVERNMENT OF GUAM
P.O. BOX 2816
AGANA, GUAM 96910

BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

REQUEST FOR EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

PARTICIPATION IS VOLUNTARY

NAME OF PARENT/GUARDIAN _____ CASE NO. _____

_____ YOLANDA CARRERA, M.D., DEDEDO

_____ WEN YEN CHEN, M.D., TAMUNING

_____ MARCIANO SANTOS, M.D., HARMON

_____ SOUTHERN REGION COMMUNITY HEALTH CENTER

_____ EFREN VALENZUELA, M.D., DEDEDO

_____ RUDOLFO SILAN, M.D., TAMUNING

_____ PUBLIC HEALTH CENTER

_____ I DO NOT NEED ADDITIONAL ASSISTANCE FROM THE MEDICAID OFFICE.

_____ I DO NEED ASSISTANCE WITH _____ APPOINTMENT _____ TRANSPORTATION

_____ I ALSO UNDERSTAND THAT DENTAL SERVICES ARE AVAILABLE AT PUBLIC HEALTH DENTAL CLINICS.

_____ _____
CLIENT'S SIGNATURE DATE

_____ _____
WORKER'S SIGNATURE DATE

TO BE COMPLETED BY THE EPSDT COORDINATOR

AUTHORIZATION FOR EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES

THE FOLLOWING INDIVIDUALS ARE ENTITLED TO ONE COMPLETE SCREENING EXAM BETWEEN THE DATES SHOWN UNDER THE PERIODICITY SCHEDULE INDICATED BELOW ONLY UPON PRESENTATION OF CURRENT MEDICAID CARD. MEDICAID WILL MAKE PAYMENT FOR SERVICES ONLY IF THE PATIENT IS ENTITLED TO MEDICAID.

SUFFIX NO.	NAME	PERIODICITY SCHEDULE	PHYSICIAN

_____ _____
EPSDT COORDINATOR'S SIGNATURE DATE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF ECONOMIC SECURITY

TO: Car Dealer

Federal regulations require our agency to determine the market value of an applicant's/recipient's vehicle for determination of eligibility. For this purpose, we are requesting the following information:

Identification Of Vehicle: _____

Year, Make and Model: _____

License Number: _____

_____ _____
Assistance Payment Worker Appraiser

_____ _____
Date Date

TO: Bank of _____

Federal regulations require our agency to determine the market value of an applicant's/recipient's vehicle for determination of eligibility. For this purpose, we are requesting the following information:

Principal Balance On Car Loan: _____

Loan Number: _____

Year, Make and Model: _____

License Number: _____

_____ _____
Assistance Payment Worker Bank Official

_____ _____
Date Date

MONTHLY REPORTING AND RETROSPECTIVE BUDGETING (MRRB)

[redacted]

* If you are receiving a Welfare Grant each month under the AFDC (Aid to Families with Dependent Children) Program, you will have to report.

* All Food Stamp households **except** those whose members are all **without** earned income and are all over 60 years of age or receive pensions under the Social Security Act for disability or blindness.

WHAT IS MONTHLY REPORTING?

* Monthly Reporting means that you will be mailed a report form each month.

* The report asks questions about changes in your situation that could affect your food stamps and/or welfare checks.

* The information you put on the form will be used by your worker to decide if you continue to be eligible for assistance and how much you should get.

* Monthly Reporting will make it easier for you to report changes to your worker because you will always know when you must report.

HOW IS YOUR INCOME DETERMINED BY THE FOOD STAMP PROGRAM?

* The first time that you apply for food stamps and/or welfare, your income will be fits.

* After your second month of receiving food stamps, your income will be calculated based on what you have earned in October will be used to determine if you are eligible in December and for what amount of benefits.

WHEN DO I REPORT AND HOW?

* MRRB will be implemented effective October 1, 1983. You will be mailed a Monthly Report Form in the last week of October and every month thereafter.

* The Monthly Report Form must be completed and returned to the Food Stamp/ Welfare Payment Office by the fifth of each month even if there are no changes to report.

* You **MUST REPORT** for the entire Report Month. The dates of the Report Month will always be printed at the top. For example, if the month indicated at the top of the form is October, the Report Month will be October 1st to October 31st.

* Sign and date the report form on the last day of the Report Month. If you sign or date the report before the last day of the Report Month, it will be returned to you.

* Your authorized representative may complete and sign the form if you are unable to do so.

* If you return the report after the **DUE DATE**, your Food Stamps/Welfare payment checks may not be received at the same time you normally do.

* You can also bring the report form into your Food Stamp/Welfare Payment Office if you

estions in completing the
t your Food Stamp Wel-

WHAT DO I HAVE TO REPORT ON THE MONTHLY REPORT FORM?

* The form contains questions and other important information.

* The form asks questions about:
  * Persons in your home
  * Income from your work
  * Cost of care for children and other persons.
  * Other Income
  * Housing costs
  * Property
  * School Attendance
  * Alien Sponsor's Income

* Be sure that all changes are reported on the form.

* You must provide receipts, paystubs and other verifications as requested on the form. If you fail to do so, your benefits may stop. When possible make a copy of your documents before submitting.

* You must make an entry in **EVERY BOX** even if only the word **"NONE"** or a zero **"0"**. **DO NOT WRITE "NA" or "Not Applicable".**

WHAT HAPPENS IF I DON'T REPORT?

* If you do not return the Report form each month, your benefits may stop.

* You will be sent a letter if you do not return your report by the Due Date. This letter will tell you what day your benefits will stop if you do not return your report form.

* If your benefits are stopped because you did not return the form, you must reapply for assistance and you must provide the information requested. Also, your benefits will be prorated in the month you reapply.

IF YOU DO NOT RECEIVE YOUR MONTHLY REPORT FORM, CONTACT THE FOOD STAMP/WELFARE PAYMENT OFFICE IMMEDIATELY.

REMEMBER ! !

* If you get a Monthly Report form, you must complete and return it by the Due Date.

* Do not fill out, sign, or date the form before the last day of the Report Month.

* Make an entry for every item on the form.

* If you do not return the report form each month, your benefits may stop.

* If you return the report from after the Due Date, your food Stamps/Welfare Payment checks may not be received at the same time you normally would.

If you do not understand this pamphlet, call the Department of Public Health and Social Services.

Angin guaha tiun comprendi guini na papileta, agangha y departamenton Public Health and Social Services.

Kung hindi mo maintindihan and pamphlet na ito, tawagan mo and Public Health and Social Services.

APS/FSP 1001

FOR OFFICE USE ONLY

EARNED INCOME	UNEARNED INCOME	EXPENSES		
$	$	Med.$	SHELTER FACTOR $	MONTHLY REPORT FOR
$	$	Dep.$	HOUSEHOLED SIZE	PROGRAM
$	$	Shl.$	GROSS INCOME $	E.W.
$	$		NET INCOME $	CASE NO.
TOTAL $	TOTAL$		RESOURCES $	

STATUS: CWC CNC INC RND

DATE Rec'd _____

Monthly Report for _____

Center _____

Village _____

Program _____

E.W. _____

Case Name _____

Case No. _____

Status: CWC
CNC
INC
RND

INSTRUCTIONS - READ CAREFULLY:

YOU MUST COMPLETE EACH ITEM ON THIS REPORT. ANSWER ALL QUESTIONS EVEN IF THERE HAS BEEN NO CHANGE.

YOU MUST ATTACH PAY CHECK STUBS AND DEPENDENT CARE RECEIPTS (AND UTILITY RECEIPTS IF YOU WISH TO HAVE ACTUAL UTILITY COST CONSIDERED FOR FOOD STAMPS)

IF YOU RECEIVE WELFARE BENEFITS, YOU ARE REQUIRED TO REPORT WITHIN 10 DAYS ALL CHANGES IN INCOME, ASSETS, HOUSEHOLD SIZE, AND OTHER CIRCUMSTANCES AFFECTING CONTINUED ELIGIBILITY AS YOU BECOME AWARE OF THEM RATHER THAN WAITING TO INFORM US ON THIS REPORT.

COMPLETE THIS FORM ON THE LAST DAY OF _____

AND RETURN IT BY _____

FAILURE TO DO SO MAY DELAY OR STOP YOUR BENEFITS.

CASE NAME _____
ADDRESS _____

DID YOU MOVE? ( ) YES ( ) NO
IF YES, COMPLETE THIS SECTION.

Street or PO.BOX No.

Apartment Building | Apt. No.

Village | Date Moved

A) INCOME

LIST ALL PERSONS WHO RECEIVED INCOME THIS MONTH. INCLUDE INCOME OF ALIEN SPONSOR AND SPOUSE. WRITE FULL NAME	ENTER THE TOTAL AMOUNT AND SOURCE OF MONEY EARNED BEFORE ANYTHING IS TAKEN OUT OF YOUR PAY (GROSS PAY) SOURCE	AMOUNT	TIPS OR COMMISSIONS. TOTAL	FREE RENT RECEIVED FOR WORK PERFORMED INSTEAD OF OR IN ADDITION TO MONEY MONTHLY VALUE	AVERAGE HOURS WORKED PER WEEK	UNEARNED INCOME RECEIVED THIS MONTH (SEE BACK OF FORM FOR LIST OF UNEARNED INCOMES AND ENTER CODE WHICH APPEARS BESIDE IT IN SOURCE COLUMN) SOURCE	AMOUNT
		$		$			$
		$		$			$
		$		$			$
		$		$			$
		$		$			$

BES-023 8/87

B) DEPENDENT CARE

LIST CHILDREN AND OTHER PERSONS WHO REQUIRE DAY CARE IN ORDER THAT SOMEONE ELSE CAN WORK. FULL NAME	AMOUNT PAID FOR EACH PERSON THIS MONTH.
	$
	$
	$
	$
	$

C) SHELTER EXPENSES

RENT/MORTGAGE	$
COOKING FUEL	$
ELECTRICITY	$
WATER	$
SEWER	$
TELEPHONE	$
OTHER(EXPLAIN)	$

D) MEDICAL EXPENSES

LIST ONLY THE MEDICAL EXPENSES OF PERSONS 60 YEARS OR OLDER OR PERSONS RECEIVING SOCIAL SECURITY OR VETERAN DISABILITY PAYMENTS.

FULL NAME	AMOUNT
	$
	$
	$
	$
	$

E) RESOURCES/ASSETS

LIST VEHICLES SUCH AS CARS, TRUCKS, BOATS, CAMPERS, MOTORCYCLES YOU OR ANYONE WHO LIVES WITH YOU OWN. IF NONE,WRITE "NONE. ATTACH VERIFICATION SUCH AS DEALER'S APPRAISAL,BANK CONTRACT, BILL OF SALE,ETC.

MAKE	MODEL	YEAR	NAME OF OWNER	PRINCIPAL AMOUNT OWED	ESTIMATED VALUE
				$	$
				$	$

LIST ALL SAVINGS AND CHECKING ACCOUNTS, STOCKS, BONDS, AND OTHER ASSETS OWNED BY YOU OR ANYONE WHO LIVES WITH YOU. INCLUDE CREDIT UNION ACCOUNTS.

CASH ON HAND $

DESCRIPTION OF ASSET	NAME OF OWNER(S)	NAME OF BANK (OR INSTITUTION)	AMOUNT (CURRENT BALANCE)
			$
			$

DID YOU OR ANYONE SELL, BUY, RECEIVE, OR DISPOSE OF ANY PROPERTY DURING THE REPORT MONTH?
IF YES, COMPLETE THIS SECTION. IF NO, WRITE "NO".

FULL NAME OF PRESENT OWNER	DESCRIPTION OF PROPERTY	VALUE	TYPE OF TRANSACTION (SELL, BUY, ETC)
		$	
		$	

F) HOUSEHOLD MEMBERSHIP

LIST ANYONE WHO MOVED IN OR OUT OF YOUR HOUSEHOLD DURING THE REPORT MONTH. IF NONE, WRITE "NONE".

FULL NAME	RELATIONSHIP HEAD OF HOUSEHOLD	CITIZENSHIP CHECK ONE U.S.	CITIZENSHIP CHECK ONE ALIEN	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	DATE MOVED IN	DATE MOVED OUT	CHECK IF DISABLED

G) **STUDENT**

LIST ANY HOUSEHOLD MEMBER 16 YEARS OR OLDER WHO GRADUATED OR DROPPED OUT OF HIGH SCHOOL.
LIST ANY HOUSEHOLD MEMBER 18 YEARS OR OLDER WHO ENROLLED IN AN INSTITUTION OF HIGHER LEARNING (EG. UNIVERSITY).

FULL NAME	AGE	CHECK ONE			WHEN (DATE)	
		ENROLLED	GRADUATED	DROPPED		

H) **STEP PARENT EXPENSE AND INCOME FOR WELFARE HOUSEHOLDS ONLY**

INCLUDE STEP PARENT INCOME IN **SECTION A** ON THIS REPORT FORM. COMPLETE THIS SECTION TO REPORT EXPENSES, CHILD SUPPORT AND ALIMONY PAYMENTS MADE DURING THE REPORT MONTH.

SUPPORT PAYMENTS MADE? NUMBER OF DEPENDENTS **LIVING** WITH STEP PARENT NOT INCLUDED IN WELFARE GRANT?

EXPENSES PAID FOR DEPENDENTS **LIVING OR NOT LIVING** WITH STEP PARENT WHO ARE CLAIMED AS FEDERAL INCOME TAX DEPENDENTS.

FULL NAME	DESCRIPTION OF EXPENSES	AMOUNT PAID	INDICATE IF LIVING WITH STEP PARENT OR NOT.

I) **OTHER CHANGES OR EXPECTED CHANGES**

EXPLAIN	DATE OF CHANGE

J) **SIGNATURE**

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE PRECEEDING INFORMATION IS TRUE, COMPLETE, AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	DATE

TELEPHONE NUMBER

K) **SPONSORS FOR HOUSEHOLDS WITH ALIEN MEMBERS ONLY**

DID YOU CHANGE SPONSORS, OR DID YOUR SPONSOR'S INCOME OR EXPENSES CHANGE DURING THE REPORT MONTH.( ) YES ( ) NO

SIGNATURE OF PERSON COMPLETING REPORT IF NOT THE HEAD OF HOUSEHOLD.

_____ DATE _____

You must remember to attach paycheck stubs, dependent care receipts (and utility receipts if you wish to have actual utility costs considered for food stamps).

If you need assistance in completing this form or have any questions regarding your rights or responsibilities, call the Food Stamp/Welfare Office in your area at one of the following numbers:

CENTRAL OFFICE, MANGILAO
734-2949

NORTHERN OFFICE, DEDEDO
632-4015

SOUTHERN OFFICE, INARAJAN
828-8613/4

CONCERNING YOUR SOCIAL SECURITY NUMBER

1. The Guam Department of Public Health and Social Services (DPHSS) has the authority to request your Social Security number under Federal Statute No. 7 USC 2025 F (7 CFR Parts 270-273), 1979; AMENDMENTS to the Food Stamp Act of 1977; under Federal Statute No. 42 USC 601-610 (45 CFR Part 206, Aid to Families with Dependent Children Regulations).

2. Under the Privacy Act of 1974 (Public Law 93-579), DPHSS is required to tell you that it is mandatory that you provide your Social Security number or apply for one if you do not have one, in order to receive benefits from Aid to Families with Dependent Children Program and the Food Stamp Program.

3. If provided, it will be used: a) as an identifier to collect information to determine initial or continuing eligibility for benefits by computer matching the records of the Department of Labor, Department of Revenue and Taxation, the Social Security Administration, etc., with this Department's records to prevent duplicate participation, to verify information given on the application and to check the identity of household members; b) for statistical purposes; c) for enforcement purposes to determine if program regulations have been violated, or if enforcement proceedings are warranted.

4. In order to participate in and receive benefits from the Aid to Families with Dependent Children and the Food Stamp Program a Social Security number must be supplied, or applied for, for each person for whom benefits are claimed.

PENALTY WARNING:

The information provided on this form will be subject to verification by Federal State and Local officials. If any is found inaccurate, you may be denied food stamps and/or be subject to criminal prosecution for knowingly providing false information. Any member of your HH who intentionally breaks any of the following rules can be barred from the Food Stamp Program for 6 months after the first violation, 12 months after the second violation, and permanently for the third violation. The individual can also be fined up to $10,000, imprisoned up to 5 years, or both. A court can also bar an individual for an additional 18 months from the Food Stamps Program. The individual may also be subject to further prosecution under other applicable federal laws.
DO NOT give false information, or hide information, to get or continue to get food stamps. DO NOT trade or sell food stamps or authorization cards. DO NOT alter authorization cards to get food stamps you're not entitled to receive. DO NOT use food stamps to buy ineligible items such as alcoholic drinks and tobacco.
DO NOT use someone else's food stamps or authorization cards for your household.

RIGHT TO APPEAL:

You have the right to request for a fair hearing if you disagree with any action or decision made as a result of the information you have provided. If you wish to request for a hearing please contact the Food Stamp/Welfare office in your area.

SOURCE OF INCOME

GG	Government of Guam employment	VA	Veteran's Pension	ST	Striker's benefits
GT	Fulltime D.O.E. teachers	DI	Dividen's and Interests	LP	Lump Sum Payments
FG	Civil Service (Federal) employment	SS	Social Security Benefits	TA	Tax Refund
PE	Private Enterprise income	AY	Alimony and Child Support	MO	Money from friends, relatives, etc.
MA	Military Earnings	PA	Welfare Payments (including GA)	PP	Payments for Property Sold
SE	Self-Employment Income,monthly	SI	Supplemental Security Income(SSI)	FO	Foster Care Payments
GR	Government of Guam Retirement	GH	GHURA Subsidy (utilities)	LI	Life Insurance benefits
FR	Civil Service (Federal) Retirement	PR	Property rent payments	SC	Scholarship, fellowship, loan
OE	Other money received	SA	Self-employment Income, Annualized		

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF ECONOMIC SECURITY

MONTHLY REPORTING AND
RECERTIFICATION SUPPLEMENTAL FORM

Case Name: _____
Head of Household

Because we have to determine your household's eligibility prospectively, meaning, income will be calculated on what you are expected to receive in the month you apply and for future months, we need you to answer the following questions.

1. HAVE YOU RECEIVED (so far this month) OR ARE YOU EXPECTING AN INCREASE OR DECREASE IN YOUR HOUSEHOLD'S INCOME THIS MONTH AND IN THE COMING MONTHS?
   YES _____ NO_____
   If you answered 'YES', please explain and provide verification to your worker.

   _____
   _____
   _____

2. HAVE YOU HAD A CHANGE (so far this month) OR DO YOU EXPECT A CHANGE IN YOUR HOUSEHOLD SIZE IN THE COMING MONTHS? YES_____ NO_____
   If you answered 'YES", please explain.

   _____
   _____
   _____

3. WHAT OTHER CHANGES ARE YOU ANTICIPATING THIS AND THE COMING MONTHS? PLEASE EXPLAIN.

   _____
   _____
   _____
   _____

_____ _____
SIGNATURE DATE

BES-022 8/87

III. Food Stamp Program

The Food Stamp Program provides monthly benefits that help low-income households buy the food they need for good health. You may qualify for food stamps if you:

- work for low wages
- are unemployed or work part time
- receive welfare or other assistance payments, or
- are elderly or disabled and live on a small income.

Under agreement with the U.S. Department of Agriculture, State public assistance agencies run the program through their local offices. The basic rules are the same everywhere.

The amount of food stamps a household can receive is based on the U.S. Department of Agriculture's Thrifty Food Plan, which is an estimate of how much it actually costs to provide your household with nutritious but inexpensive meals. This cost estimate is revised periodically to keep pace with food prices.

If your household meets the program's eligibility tests, the amount of food stamps you receive will also depend on the number of people in your household and on the amount of monthly income left after certain deductions are subtracted.

For most households, food stamps are only part of their food budgets; they must spend some of their own cash along with their food stamps in order to buy enough food for a month.

For more information, contact your local food stamp office. It is probably listed under "Social Services Department" or "Food Stamps" in the State or local government pages of the telephone directory.

FOOD STAMP PROGRAM INCOME STANDARDS
(Effective October 01, 1988)

Household Size	Gross Monthly Income Level	Allotment	Net Monthly Income	Separate Household Gross Monthly Income Level For Elderly & Disabled
01	626	132	481	794
02	838	243	645	1,063
03	1,050	348	808	1,333
04	1,263	442	971	1,602
11	2,751	1,092	2,117	3,490
12	2,964	1,191	2,281	3,760
13	3,177	1,290	2,445	4,030
14	3,390	1,389	2,609	4,300
15	3,603	1,488	2,773	4,570
Each additional Member	+213	+99	+164	+270

Food Stamp Deductions, Effective October 01, 1988

Guam Standard Deduction $213.00
Dependent Care Deduction . . . . . $160.00 Per Dependent

Shelter Deduction:

1. Without Elderly $206.00
2. With Elderly - no limit

Standard Utility Allowances

	ELECTRICITY	WATER	SEWER	GAS	TELEPHONE
01	37.00	6.00	8.00	8.00	12.00
02	42.00	7.00	8.00	8.00	12.00
03	42.00	7.00	8.00	8.00	12.00
04	49.00	9.00	8.00	15.00	12.00
05	56.00	10.00	8.00	15.00	12.00
06	63.00	13.00	8.00	15.00	12.00
07	71.00	16.00	8.00	23.00	12.00
08	74.00	17.00	8.00	23.00	12.00
09	79.00	20.00	8.00	23.00	12.00
10	79.00	20.00	8.00	23.00	12.00
11	81.00	21.00	8.00	23.00	12.00
12	81.00	21.00	8.00	23.00	12.00

For a household size beyond thirteen (13) and over, use the utility allowance for the household size of twelve (12).

Department of Public Health and Social Services
Division of Public Welfare
Bureau of Economic Security
P.O. Box 2816, Agana, Guam 96910

CONSENT FOR UTILITY DEDUCTION

Name _____

Case # _____

Address _____

_____

Social Security No. _____

I, _____ , authorize my case worker to base my utility expense on STANDARD/ACTUAL. *(Please circle one)*

_____
DATE

_____
CLIENT'S SIGNATURE

Department of Public Health and Social Services
Division of Public Welfare
Bureau of Economic Security
P.O. Box 2816, Agana, Guam 96910

CONSENT FOR DISCLOSURE OF INFORMATION

Address _____

_____

Social Security No. _____

I, _____, residing at _____
on _____ hereby authorize Food Stamp and Public Assistance Programs to verify my employment income, disability and retirement benefits; savings and checking accounts; Real and Personal Property; Life and Medical Insurance coverages; and any other information relevant to my eligibility for participation and compliance in any of the above programs.

I also authorize any person, partnership, corporation, association or government agency possessing information on such matters, to release such information.

I understand this information is confidential and will be used by the program staff only for the purpose of verifying my eligibility to participate in the Food Stamp/Public Assistance programs.

I further understand that my refusal to sign this consent may result in termination or denial of benefits.

_____ _____
Client/Guardian/Parent Signature Date

_____ _____
AUTHORIZED STAFF Date

_____ _____
WITNESS (IF NEEDED) Date

BES-40
3/88

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
FOOD STAMP PROGRAM

YOUR FOOD STAMP RIGHTS

You have the right to:

- Receive an application when you ask for it.
- Turn in your application the same day you receive it.
- Receive your food stamps *(or be notified that you are not eligible for the program)* within 30 days after you turn in your application.
- Receive food stamps within a few days if you are eligible and have little or no income.
- Have a fair hearing if you disagree with any action taken on your case.

If you believe that you or any group of individuals have been discriminated against by the Food Stamp Program because of age, sex, color, race, handicap, religious creed, national origin or politacal beliefs, write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

I have read and understand my RIGHTS.

_____
Signature / Date

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
FOOD STAMP PROGRAM

NOTICE

- Changes in any source of income.
- If anyone in your household gets a car or other licensed vehicle such as a motorcycle, boat, etc.
- If your household's total savings, cash on hand, property and other resources increase, or amount to $1,500 or more.
- The number of people in your household changes.
- Your new address, new rent or mortgage costs if you move.
- If your utilities or dependent care costs (babysitting) change.
- When the total medical expenses of members 60 years or older, or whose Social Security Disability payments go up or down by $25 or more.

Do NOT wait for your renewal appointment.

You MUST report these changes within 10 days you become aware of them.

The Food Stamp Change Report Form is provided for this purpose. Drop it off at the Food Stamp Office at which you were processed, or mail it to the office in the postage paid envelope provided with the form.

IF YOU PURPOSELY HOLD BACK INFORMATION ABOUT CHANGES IN YOUR HOUSEHOLD, YOU WILL OWE US THE VALUE OF ANY EXTRA FOOD STAMPS YOU RECEIVE, AS A RESULT. YOU MAY ALSO BE BARRED FROM THE FOOD STAMP PROGRAM FOR 3 MONTHS TO 2 YEARS, AND BE FINED, IMPRISONED, OR BOTH.

THE FOOD STAMP OFFICE

My caseworker has explained to me my reporting responsibilities. I understand this requirement and the penalties for failing to report any changes in my household circumstances or for withholding any information that is necessary in determining my eligibility for program benefits.

_____
Signature of Applicant/Authorized Representative

Original: casefile

The following certifications are to be signed as indicated when the person whose name appears on the front of this card is physically unable to obtain the food coupons.

CERTIFICATION

By - Authorized Household Member (Name must appear on ID Card)

authorization to participate cards to the person whose signature appears below for the purpose of making the current redemption for me.

_____
Household Signature Authorizing Emergency Representative

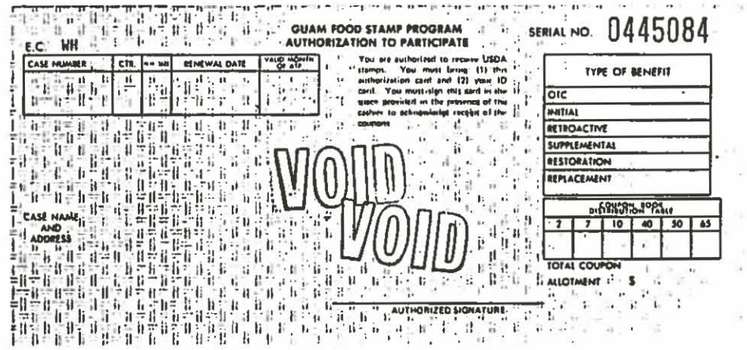
CERTIFICATION
By - Emergency Authorized Representative

I certify that I have received the identification and ATP cards from the person whose signature appears above and will return the food coupons and ID card to that person.

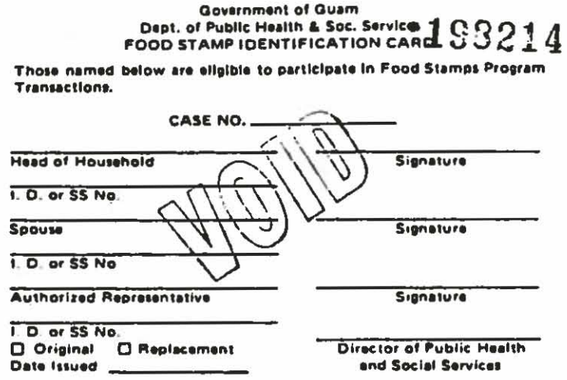
_____
Signature of Emergency Authorized Representative

Emergency representative must present the ID card and ATP card of the authorized household member.

A.T.P. CARD



FOOD STAMP I.D. CARD



This card is to be used whenever you are using your Food Stamps. It will have your name and signature along with your spouse's name and the name of anyone who is assisting you in obtaining the Food Stamp benefits.

If you lose your ID Card, notify your worker.

GUAM EMPLOYMENT AND TRAINING PROGRAM

The Department of Public Health and Social Services implements the Guam Employment and Training Program in coordination with the Department of Labor, Agency of Human Resource Development, and the Guam Community College. The program provides employment and training opportunities to Food Stamp recipients for mainstreaming into the employment market thereby decreasing dependency on the Food Food Stamp Program.

1. Job Development
2. On the Job Training
3. Summer Youth Employment and Training Program (SYETP)
4. Apprenticeship Training Program

Non-Work Competent

1. Job Enhancement
2. Independent Job Search
3. Institutional Training

WHO ARE REQUIRED TO WORK REGISTER

1. Able to bodied men and women receiving assistance from the Food Stamp Progam.
2. Between the ages of 16 - 59 years of age.
3. Unemployed or working and earning less than 30 hours a week X the minimum wage.
4. If you are retired and not involved in any form of gainful employment.

WHO ARE REQUIRED TO WORK REGISTER

1. Under the age of 16 years of age or 60 years of age and over.
2. Enrolled in a secondary school or in an employment and training program at least half time.
3. Disabled physically or mentally as certified by a licensed physician.
4. Is currently enrolled in the WIN program.
5. Employed full-time at 30 hours a week of earning at least $100.50 in gross wages weekly.
6. Caretaker of a child under 6 years of age or a person who is physically or mentally incapable of taking care of self.
7. Pregnant over 7 months or considered a high risk pregnancy as determined by a licensed physician.

IF YOU FIT IN ANY OF THE CATEGORIES LISTED, PLEASE ADVISE YOUR CASEWORKER AS YOU OR A MEMBER OF YOUR HOUSEHOLD WILL BE REQUIRED TO REGISTER FOR THE GUAM EMPLOYMENT AND TRAINING PROGRAM.

ceive a letter indicating whom in your household must comply. You must ensure that you comply to all appointments made and to all requirements set and required by the Department of Labor, Agency of Human Resource Development, or the Guam Community College.

2. Ensure that any documentation required of you to furnish is timely submitted to your caseworker or to the Department or Agency requesting for the information. Failure to comply may result in the denial of your application or by the "TERMINATION" of your benefits.
3. If you are selected you must appear for an assessment interview at the Department of Labor to determine whether to be place into training or to conduct competitive job search. You must bring your Passport, Certificate of Naturalization, Alien Registration Card, ID Card issued by the Guam Police Department, or any form of employment authorization. This is required by Federal Law in order to determine your citizenship or working status.

WHAT HAPPENS IF I DO NOT COMPLY

1. For any reason that you are reported in non-compliance by the Department of Labor, you will be terminated from receiving benefits for a period of two (2) months. In order to not be disqualified from the Food Stamp Program, you must do the following:

   A. Ensure to call your caseworker, the Guam Employment and Training Coordinator, or the Department of Labor if you cannot make it to a schedule appointment. Failure to contact any of those mentioned after the appointment may result in the termination of your benefits.
   B. Ensure to provide the documents requested in a timely manner. Failure to do so may result in termination or the delayed processing of your Food Stamp Benefits.
   C. Remember, the Guam Employment and Training Program exist as a condition of eligibility on receiving your Food Stamp benefits. At any time you do not comply may affect your benefits. Protect your benefits as this is a privilege not a right.

PARTICIPANT REIMBURSEMENT

YOU MAYBE ENTITLED TO RECEIVE UP TO $50.00 OF REIMBURSEMENT FOR PARTICIPATING IN THE GUAM EMPLOYMENT AND TRAINING PROGRAM (ETP).

[redacted]NT IS AVAILABLE TO ALL ETP PARTICIPANTS FOR EXPENDITURES [redacted]SPORTATION, AND CHILD CARE WHILE PARTICIPATING IN THE EMPLOYMENT AND TRAINING PROGRAM.

TO REQUEST FOR THIS REIMBURSEMENT, YOU MUST PRESENT THE FOLLOWING DOCUMENTS TO THE FOOD STAMP OFFICE:

1) ANY RECEIPT FOR GASOLINE YOU PAID FOR IN ORDER FOR YOU TO PARTICIPATE IN ETP DURING THE PERIOD OF PARTICIPATION (OR)

2) ANY RECEIPT OR STATEMENT FROM THE PERSON WHO PROVIDED TRANSPORTATION SERVICE IN ORDER FOR YOU TO PARTICIPATE IN ETP DURING THE PERIOD OF PARTICIPATION (OR)

3) ANY RECEIPT OR STATEMENT FROM THE PERSON OR BUSINESS WHO PROVIDED CHILD CARE IN ORDER FOR YOU TO PARTICIPATE IN ETP DURING THE PERIOD OF PARTICIPATION.

YOU MUST SUBMIT YOUR DOCUMENTS TO YOUR CASE WORKER OR TO ETP COORDINATOR **MR. ROLAND VILLAVERDE** AT THE FOOD STAMP OFFICE, MANGILAO, WITHIN 10 DAYS AFTER THE END OF THE ACTIVITY MONTH IN ORDER TO QUALIFY FOR THIS REIMBURSEMENT.

IF YOU NEED ADDITIONAL INFORMATION, PLEASE CALL YOUR WORKER OR **MR. ROLAND VILLAVERDE AT 734-2951 THRU 9.**

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF ECONOMIC SECURITY
POST OFFICE BOX 2816
AGANA, GUAM 96910

GUAM EMPLOYMENT AND TRAINING PROGRAM

CASE NUMBER

MAILING ADDRESS

CASE NAME

SOCIAL SECURITY NUMBER

GETP PARTICIPANT NAME

SOCIAL SECURITY NUMBER

I AM REQUESTING FOR THE REIMBURSEMENT OF THE FOLLOWING EXPENSES INCURRED IN THE MONTH OF _____

☐ Child Care $_____

☐ Transporation $_____

SIGNATURE OF ETP PARTICIPANT: _____

DATE: _____

FOR OFFICIAL USE ONLY

DATE RECEIVED: _____

BY WHOM: _____

☐ Attachment of Receipts

APPROVED BY:

Date Direct Payment Prepared

Date PCCU Supervisor Initial

ROLAND VILLAVERDE
Program Coordinator II

BES FORM NO. 88-41

WORK REGISTRATION FORM

WORK HISTORY - Describe your most important jobs (including military). Begin with your present or most recent. List main duties/assignments, tools, or equipments used, etc. below.

COMPANY NAME	JOB TITLE:
ADDRESS	DUTIES:
TYPE OF BUSINESS	
PAY	
COMPANY NAME	JOB TITLE:
ADDRESS	DUTIES:
TYPE OF BUSINESS	
DURATION / ENDING DATE / PAY	
REASON FOR LEAVING JOB	
COMPANY NAME	JOB TITLE:
ADDRESS	DUTIES:
TYPE OF BUSINESS	
DURATION / ENDING DATE / PAY	
REASON FOR LEAVING JOB	

HNDCP	VETERAN	FS	ECON DIS		OFFICE USE— DO NOT WRITE BELOW THIS LINE OCCUPATIONAL TITLE	MOS. EXP.	OCC. CODE
					1)		
					2)		
					3)		

PRINT NAME (Last, First, Mid, Init.) — SOC. SEC. NO.

MAILING ADDRESS (P.O. Box or Street, City State, Zip)

TELEPHONE NO.	SEX	BIRTH DATE	U. S. CITIZEN	DATES OF MILITARY SERVICE	REGISTRATION DATE (Mo. Day, Yr.)
	___Male ___Female		___Yes ___No	Entered _____ Released _____	

NO. IN FAMILY

FAMILY INCOME (Last 12 mos. before taxes $ _____)

HIGHEST GRADE OF SCHOOL OR COLLEGE COMPLETED _____ If you have a college degree(s) describe kind of degree(s) & major course(s) of study _____

LIST ANY TRAINING YOU HAVE RECEIVED SUCH AS VOC TECH OR MILITARY SCHOOLING _____

DO YOU HAVE A PHYSICAL OR MENTAL IMPAIRMENT WHICH WOULD IMPOSE LIMITS ON YOU AS TO WHAT KIND OF WORK YOU CAN DO ___ No ___ Yes
IF YES, DESCRIBE _____

IF NEEDED FOR WORK, DO YOU HAVE
Driver's License Automobile
___Operator's ___Yes
___Chauffeur's ___No
Work Tools ___Yes ___No
If yes, list kind _____

KIND OF WORK WANTED—BE SPECIFIC
1st Choice
2nd Choice
LOWEST PAY ACCEPTABLE $ per

DO YOU TYPE	TAKE SHORTHAND
___Yes ___No	___Yes ___No
If yes, WPM	If yes, WPM

LIST OFFICE MACHINE(S) YOU OPERATE:

SKILLED TRADES: What equipment or machinery do you operate, please list if any:

DATES

WORK APPLICATION

EDW'S INIT.

ETP-511
REV 4/83

DO NOT WRITE ON THIS SIDE OF FORM

SUMMARY OF OTHER WORK EXPERIENCE	OTHER SKILLS, KNOWLEDGES, ABILITIES	TEST RESULTS

GROUP
___ W NH
___ B NH
___ HISP
___ AI/ALAS NAT.
___ AS. PAC. IS.,

HNDCP ____ No
___ PHY
___ MRTD
___ MRSTD

AGE

VETERAN ___ No

Viet Era	Other Vet
4	7 NOT DIS.
5	8 DIS.
6	9 SP. DIS.

FOOD STAMPS _____ No
___ Head Hshld.
___ Other
___ Job Search Act (Head Hshld.)
___ Job Search Act (Other)
___ Exempt Parent

Case Name/Wkr. ID No.

Cert. Period

Exempt from Job Search
Yes No

WIN CASE NO.

RECORD OF SERVICE

DATE			EMPLOYER, AGENCY OR TYPE	JOB TITLE OR PURPOSE	JOB ORDER NO.	REFERRAL ACTIVITY		
Called	Referred	Other				Duration	Pay	Results

DIVISION OF PUBLIC WELFARE

••••••••••PLEASE READ••••••••••••••••••••PLEASE READ••••••••••

"IMPORTANT NOTICE"

ood Stamp Program will implement the following changes in the use of an authorized representative by households receiving food stamp beneftis.

1) An authorized representative may represent a maximum of three (3) households. THERE WILL BE NO EXCEPTIONS TO THIS POLICY!

2) Food Stamp Households must declare the person they wish to be their authorized representative on the Food Stamp application, either at the time of application or recertification.

3) When a person is chosen as Authorized Representative (AR), the person must complete the AR information sheet and receive approval from the Food Stamp Program before he or she can function as an Authorized Representative. The information sheet must be completed in triplicate (3 copies).

   1). Authorized Representative's Copy
   2). Household's Copy
   3). Food Stamp Programs" File Copy

4) If an Authorized Representative is charge with any misrepresentation or abuses in the Food Stamp Program, he or she will be disqualified from being an AR for up to (1) year for the first violation. If a second violation is committed, he or she will be <u>permanently</u> disqualified from being an Authorized Representative for any Food Stamp household.

Should you have any questions, please contact your caseworker.

Telephone: **Dededo - 632-4015 thru 4018**
Central - 734-2951 thru 59
Inarajan - 828-8613

AR FORM-85

AUTHORIZED REPRESENTATIVE REGISTRATION FORM

AUTHORIZED REPRESENTATIVE

NAME: _____
ID/SSN: _____
ADDRESS: _____
_____
EMPLOYER: _____

HOUSEHOLD

CASE NAME: _____
CASE NUMBER: _____
ID/SSN: _____
ADDRESS: _____
_____

Is the authorized representative an employee of DPH&SS? [ ] YES [ ] NO;
an ATP issuance teller? [ ] YES [ ] NO; an authorized retailer? [ ] YES [ ] NO

Is the authorized representative presently disqualified from participation in the Program? [ ] YES [ ] NO

Is the authorized representative already designated to represent any other household? [ ] YES [ ] NO

If so, please indicate the other household(s) being represented:

(1) CASE NAME: _____ CASE NUMBER: _____
(2) CASE NAME: _____ CASE NUMBER: _____
(3) CASE NAME: _____ CASE NUMBER: _____

The authorized representative is authorized by the household to be interviewed on behalf of the household; pick up ATP cards, transact ATP cards; and/or use coupons to purchase food for the household.

HOUSEHOLD CERTIFICATION STATEMENT:

I certify that the above information is true and correct to the best of my knowledge; I am freely requesting the designation of an authorized representative; and I understand my liability for any overissuance of benefits which may result from erroneous information given by the authorized representative.

_____ _____
DATE ( ) HEAD OF HOUSEHOLD ( ) SPOUSE

AUTHORIZED REPRESENTATIVE CERTIFICATION STATEMENT:

I certify that the above information is true and correct to the best of my knowledge; I am aware of my responsibilities as an authorized representative to accurately represent household circumstances, ensure that the household receives the correct amount of benefits, properly utilize coupons, and report any changes in household circumstances; and I am aware of the penalties of disqualification for misrepresentation of information or misuse of benefits.

_____ _____
DATE AUTHORIZED REPRESENTATIVE

[ ] ACCEPTED [ ] NOT ACCEPTED

COMMENTS: _____
_____

_____ _____
DATE CASEWORKER

White - File, Yellow - Client, Pink - Certification Clerk

HOW DO I USE MY FOOD STAMPS

You are receiving food stamps so that you may purchase food ...ed for good health. The amount you receive is based on ... Department of Agriculture's Thrifty Food Plan, which ...timate of what it costs to provide nutritious but inexpen-...eals. Food stamps are used like cash and most grocery stores accept them; however, there are some basic rules which you and the grocer must follow.

ELIGIBLE PRODUCTS

All food or food products for human consumption. Vegetable seeds and food producing plants, roots, and trees. Also, seeds and plants to produce spices and herbs for use in cooking foods.

Items considered **"health foods"** such as wheat germ, brewers yeast, sunflower seeds packaged for human consumption, rose hips powder, and enriched or fortified foods.

Infant formula, diabetic or diebetic foods.

Deposits on returnable bottles or containers. Distilled water and ice, if labeled **"for human consumption"**.

Items used in the preparation and/or preservation of food such as spices and herbs, pectin, lard or shortening.

Snack foods such as candy, potato or tortilla chips, chewing gum, and soft drinks.

Meals prepared for and delivered or served to elderly or handicapped food stamp recipients if the public or private organization is authorized to accept food stamp coupons.

INELIGIBLE PRODUCTS

Alcoholic beverages, and tobacco. Non-food items such as soap and toiletries, paper products, cleaning products, and cooking utensils.

Items used for gardening such as fertilizer, peat moss and similar items.

Items not intended for human consumption such as laundry starch, dog and cat food, seeds packaged as bird seed, and decorative dye as that used to color hard cooked eggs. Items for food preservation such as pressure cookers, canning, jars and lids, paraffin, freezer containers, and wrapping paper.

Therapeutic products and deficiency correctors such as vitamins and mineral in any form.

All health aids such as aspirin, cough drops or syrups and other cold remedies, antacids, and all patent medicines.

Hot foods and hot food products sold in grocery stores, hot at the point of sale, and ready for immediate consumption. All foods marketed to be heated and served on the premises, and any prepared food sold to be consumed on the premises.

When going to the store, be sure you have the following with you.

1) Food Stamps coupons and the booklet cover in which they came.
2) Your Food Stamp ID card.

As you put your groceries in the cart, keep food items which can be purchased with food stamps separate from items which you will purchase with cash. By doing this, you can get through the

When you reach the checkout counter, tell the cashier that you are paying with food stamps before the items are checked. When paying with food stamps, you may be asked to show your ID card. Your coupons should be within the cover, or you should have the cover with you. The coupons are stamped with a serial number which matches the number on the cover. The grocer will not accept loose coupons of a value greater than $1 for which you have no cover with the same serial number. Try to pay to the nearest dollar.

For change you will receive $1 coupons only. do not accept $1 coupons if they have been endorsed or cancelled, and do not accept as change, coupons of values greater than $1. For change amounts under $1, you have three options which you can choose for change amounts. **(1)** You may receive cash in amounts of 99 cents or less. **(2)** You may "trade out": or obtain additional eligible foods to make up the difference. **(3)** You may pay the store the difference in cash.

Food stamp coupons may not be used to pay for credit or charge accounts. They can be redeemed only at the time of a food purchase.

How To Request A Fair Hearing

As an applicant or participant in the Food Stamp Program, you have the right to a fair hearing if you on your case. A fair o explain to a hear- ith the Food Stamp our case. Below are the steps to follow when requesting a fair hearing.

1. You can request a hearing if you disagree with any action taken by the Food Stamp Office within 90 days from the date the action was taken.

2. A request for hearing can be orally expressed or written. You or Your representative can request the fair hearing. Tell the Food Stamp Office that you want a fair hearing. Forms are available for this purpose.

3. An agency conference will be available to you upon request. This is optional and does not replace the fair hearing. The conference is held with the Program Supervisor and may lead to a resolution of your complaint or disagreement. However, a hearing will still be held unless you make a written withdrawal of your request for a fair hearing.

4. A fair hearing will be set up with a hearing official and a hearing authority who will decide on the case.

5. You or your representative may examine your case file prior to the hearing in order to prepare its presentation.

6. At least 10 days before the hearing, a written notice will be sent to you informing you of the time, date, and place of the hearing.

7. If the time of the hearing is inconvenient, you should notify the Food Stamp Office. The hearing can be rescheduled. However, failure to appear for the fair hearing without good cause is reason to dismiss the case.

8. After the hearing, the hearing authority will decide on the case. You will be notified of this decision.

9. If you are not satisfied with the decision of the hearing, the household can pursue judicial review. The decision of the hearing authority can be reversed.

"YOUR RIGHTS IN A FAIR HEARING"

- ***Right to a timely hearing***
- ***Right to have the Food Stamp Office help you in preparing the hearing request.***
- ***Right for available legal service***
- ***Right for advance notice of date, time, and place of hearing***
- ***Right to postpone the hearing up to 30 days***
- ***Right to examine all documents and records in order to prepare for the hearing***
- ***Right to present your case or have it presented by legal counsel or others***
- ***Right to bring witnesses***
- ***Right to question or refuse any testimony or evidence***
- ***Right to advance arguments without undue interference***
- ***Right to submit evidence to establish all pertinent facts in the case***

FOR MORE INFORMATION, CONTACT YOUR FOOD STAMP OFFICE.

Filing A Discrimination Complaint

It is the policy of the Food Stamp Office to administer and provide service to any applicant or eli-

a complaint.

1. If you feel you have been discriminated against, you may file a complaint with the Supervisor of the Food Stamp Program. You may make this complaint verbally or in writing. Forms are available at the Food Stamp Office for this purpose.

2. Your complaint must be submitted, within 180 days from the date of the alleged discrimination.

3. An investigation by the Department will follow the filing of your complaint.

4. A report will be submitted to FNS for every discrimination complaint processed. This report will contain the findings of the investigation and the corrective action taken.

5. You also have the right to file a written complaint with the Food and Nutrition Service to the Secretary or Administrator, FNS, Washington, DC 20250.

6. The written complaint should contain the following:

   a. Name, address, phone number, or other of contacting person alleging discrimination.

   b. Location and name of organization or office accused of discrimination.

   c. Nature of incident or action that led to alleged discrimination.

   d. Reason for the alleged discrimination (age, race, color, sex, handicap, religious

   f. Date or dates alleged discrimination occurred.

7. A complaint must be submitted within 180 days from the date of the alleged discrimination. FNS may extend this date.

FOOD STAMP OFFICE:

Mangilao	**734-2951 - 59**
Dededo	**632-4015/6**
Inarajan	**828-8613**

FOR MORE INFORMATION, CONTACT YOUR FOOD STAMP OFFICE.

FOOD STAMP AND PUBLIC ASSISTANCE

QUALITY CONTROL

ram provides a way for low-income people to buy the amount and variety of good l stamp recipients include the working poor, households headed by women who must erly and disabled people temporarily out of work and others who have in common hemselves and their families a healthful diet.

IMPROVING PROGRAM MANAGEMENT

The U.S. Department of Agriculture and State and local agencies that administer the Food Stamp Program have found that misinterpretation of program rules or wrongful application of the national standards can result in lots of benefits to clients and/or increased program costs. By identifying areas prone to error at local levels, action can be take to improve the situation, thereby insuring that food stamp dollars are spent as intended by the Congress.

HOW IT IS DONE - - - THE SYSTEM

It is called Quality Control (QC) and it is a standard system designed by FNS to provide State and Federal agencies with information on how well the program is being run. Each State operates its own QC system with USDA's Food and Nutrition Service (FNS) periodically reviewing th State's system to insure that it accurately reflects the situation.

HOW QC WORKS

Just as a factory examines a sample of its products to insure that specifications are being met, a sample number of food stamp cases are examined each month to see that the rules were properly applied and correct decisions were made.

Who is selected for review - - - Both households approved to receive food stamps and households who were denied or had benefits discontinued are examined. These sample households are randomly selected.

Records check - - - The QC reviewer first checks the case file in the local food stamp office for errors of procedure - - were all the forms filled out completely and correctly are there any mathematical errors in calculating benefits, etc.?

Home visits - - - The reviewer then arranges to visit the home. The client must cooperate in making a mutually convenient appointment and cooperate with the interviewer or risk being disqualified from the Food Stamp Program.

During the home visit, the reviewer examines, in detail, the household's eligibility for food stamps, i.e. income, assets, expenses, eating arrangements, etc. The reviewer will verify the information by examining bank books, pay stubs, rent, utility and medical receipts, and may visit employers and banks, if necessary, to fully verify the circumstances of the households.

WHAT IS DONE WITH QC DATA

Information collected in these reviews is used in two ways:

Individual cases - - - When a reviewer discovers that a household has received food stamps incorrectly, or been

wrongfully denied benefits, a report is sent to the local food stamp office so that the error can be immediately corrected.

Error trends - - - Results from individual cases are regularly summarized into reports by the States. The States then use this more general data to spot error trends in the program. Perhaps one office is making more errors than similar offices because of a procedure or misunderstanding. Likewise, if a procedure seems prone to errors, the State can adjust to try to lower the error rate.

[redacted]

the program.

REWARDING STATES FOR LOW ERROR RATES

FNS pays 50% of the cost of operating the Food Stamp Program. When a State's QC system reflects a low or reduced error rate which is substantiated by FNS' QC system, then FNS will pay more of the operating costs.

The standards for participating in the Food Stamp Program are the same for everyone without regard to race, color, sex, religious creed, national origin, political beliefs, age or handicap.

PENALTY WARNING

OLD IS APPLYING FOR OR IS RECEIVING FOOD STAMPS, LY WITH THE FOOD STAMP PROGRAM'S RULES. ANY OUSEHOLD WHO COMMITS AN INTERNTIONAL PROGRAM VIOLATION AS DETERMINED THROUGH AN ADMINISTRATIVE DISQUALIFICATION HEARING (OR WAIVED THE RIGHT TO AN ADMINISTRATIVE DISQUALIFICATION HEARING) OR BY A COURT OF APPROPRIATE JURISDICTION (OR BY SIGNING DISQUALIFICATION CONSENT AGREEMENT) SHALL BE INELIGIBLE TO PARTICIPATE IN THE PROGRAM FOR: 6-MONTHS FOR 1st VIOLATION, AND 12-MONTHS FOR 2nd VIOLATION AND PERMANENTLY FOR 3rd VIOLATION. HE/SHE WILL ALSO BE SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE FEDERAL OR TERRITORIAL LAWS. THE FOOD STAMP RULE PROVIDE THAT YOU SHOULD NOT MAKE FALSE OR MISLEADING STATEMENT, OR MISREPRESENT OR CONSEAL OR WITHHOLD FACTS, OR COMMIT ANY REGULATIONS, OR ANY GUAM LAWS RELATING TO THE USE, PRESENTATION, TRANSFER, ACQUISITION, RECEIPT, OR POSSESSION OF FOOD STAMP COUPONS OR AUTHORIZE TO PARTICIPATE (ATP) CARDS.

ALL INFORMATION GIVEN IS SUBJECT TO VERIFICATION BY FEDERAL AND LOCAL OFFICIALS.

_____ SIGNATURE

_____ DATE

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF ECONOMIC SECURITY

FOOD STAMP PROGRAM

ISSUANCE CENTERS:

Bank of Guam Issuance Center, Payless Market
Farenholt Avenue, Tamuning

Hours: 9:00 - 4:00 First 5 working days of the month
9:00 - 12:00 Other working days of the month

Bank of Guam, Dededo Branch (next to Chamorro Mart)

Hours: 9:00 - 3:00 First 5 working days of the month only.
CLOSED Other working days of the month.

BANK OF GUAM MOBILE UNIT:

Monday --	Talofofo	8:00 - 10:00 a.m.
	Yona	10:30 - 12:30 p.m.
	Chalan Pago/Ordot	1:30 - 3:30 p.m.
Tuesday -	Santa Rita	8:00 - 10:00 a.m.
	Agat	10:30 - 12:30 p.m.
	Barrigada	1:30 - 3:30 p.m.
Wednesday -	Commercial Port	9:00 - 12:00 p.m.
	Piti	12:10 - 12:30 p.m.
Thursday -	Mangilao/UOG Adm. Parking Lot	10:00 - 2:30 p.m.
Friday --	Umatac	8:00 - 10:00 a.m.
	Merizo	10:30 - 12:30 p.m.
	Inarajan	1:30 - 3:30 p.m.

DO YOU HAVE ANY QUESTIONS ABOUT FOOD STAMPS?

Call any of the Food Stamp Offices:
Central, Mangilao -- 734-2951/59
Southern, Inarajan - 828-8613
Northern, Dededo --- 632-4015/6