



DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
FOOD STAMP/TEMPORARY ASSISTANCE INTERVIEW GUIDE
(A COMPLETED FS-1 OR IM-1 MUST ACCOMPANY THIS GUIDE)

CASE NAME					CASE DCN		DATE		
DOES ANY ADULT IN THE EU SPEAK ENGLISH WELL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHAT LANGUAGE DO YOU SPEAK?									
IS THIS EU MIGRANT/SEASONAL FARM WORKER, OR DESTITUTE? <input type="checkbox"/> YES <input type="checkbox"/> NO									
1. EU MEMBERS									
NAME	HISPANIC <input type="checkbox"/> YES <input type="checkbox"/> NO	RACE*/ SEX /	Relation- ship To Applicant	MARITAL STATUS	DATE OF BIRTH	SSN	SSN Agree to Apply	SSN Agree to Provide	DV <input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	/							<input type="checkbox"/> YES <input type="checkbox"/> NO
* 1 – WHITE 2 – BLACK/AFRICAN AMERICAN 4 – AMERICAN INDIAN/ALASKA NATIVE 5 – ASIAN 6 – NATIVE HAWAIIAN/PACIFIC ISLANDER									
2. CHILD IN HOME									
CHILD	IN THE HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	RESIDENT ADDRESS COUNTY/STATE	LIST REASON AWAY FROM HOME	START DATE	EXPECTED RETURN DATE				
	<input type="checkbox"/> YES <input type="checkbox"/> NO								
	<input type="checkbox"/> YES <input type="checkbox"/> NO								
	<input type="checkbox"/> YES <input type="checkbox"/> NO								
	<input type="checkbox"/> YES <input type="checkbox"/> NO								
EBT CARD NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO TA BENEFIT DELIVERY <input type="checkbox"/> DDP <input type="checkbox"/> EBT									
3. AUTHORIZED REPRESENTATIVE/PROTECTIVE PAYEE									
NAME	PROGRAM <input type="checkbox"/> FS <input type="checkbox"/> TA	<input type="checkbox"/> APPLY	<input type="checkbox"/> ACCESS	<input type="checkbox"/> BOTH	<input type="checkbox"/> Protective Payee				
	PROGRAM <input type="checkbox"/> FS <input type="checkbox"/> TA	<input type="checkbox"/> APPLY	<input type="checkbox"/> ACCESS	<input type="checkbox"/> BOTH	<input type="checkbox"/> Protective Payee				
4. RECEIVED OUT OF STATE IN LAST 60 DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)									
NAME(S)	PROGRAM <input type="checkbox"/> FS <input type="checkbox"/> TA	STATE	COUNTY	LAST MONTH RECEIVED IN ANOTHER STATE					
	<input type="checkbox"/> FS <input type="checkbox"/> TA								
NAME(S)	PROGRAM <input type="checkbox"/> FS <input type="checkbox"/> TA	STATE	COUNTY	LAST MONTH RECEIVED IN ANOTHER STATE					
	<input type="checkbox"/> FS <input type="checkbox"/> TA								
NOTES									

5. DO ANY OF THE EU MEMBERS HAVE CASH ON HAND, CHECKING ACCOUNTS, SAVINGS ACCOUNTS, CERTIFICATES OF DEPOSIT, STOCKS, SAVINGS BONDS, CORPORATE BONDS, DEBTS OWED TO THEM, TRUSTS, OR OTHER INVESTMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
OWNERS	CONTRIBUTES TO ACCT <input type="checkbox"/> YES <input type="checkbox"/> NO	VALUE	DESCRIPTION OF RESOURCE AND LOCATION		
	<input type="checkbox"/> YES <input type="checkbox"/> NO				
	<input type="checkbox"/> YES <input type="checkbox"/> NO				
	<input type="checkbox"/> YES <input type="checkbox"/> NO				
NOTES					
6. DO ANY OF THE EU MEMBERS OWN OR ARE THEY PURCHASING A PREPAID BURIAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
NAME	COMPANY	POLICY NO.	CSV	ISSUE DATE	IRREVOCABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
					IRREVOCABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
					IRREVOCABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
					IRREVOCABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
7. ARE ANY OF THE EU MEMBERS CURRENTLY ON STRIKE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, EXPLAIN)					
NAME	STRIKE LOCATION	PRE-STRIKE RESOURCES	NOTES		
8. DO ANY OF THE EU MEMBERS HAVE INCOME FROM WAGES, CHILD SUPPORT, SELF-EMPLOYMENT, TEMPORARY ASSISTANCE FROM ANY STATE, SOCIAL SECURITY, SSI, VA, BLACK LUNG, RAILROAD PENSIONS, UNEMPLOYMENT COMPENSATION, AGRICULTURE PAYMENTS, TRAINING PROGRAMS, STUDENT INCOME, HOUSING ASSISTANCE OR VOUCHERS, CASH ASSISTANCE OR ANY OTHER FORM OF INCOME? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
NAME	EMP ID NUMBER	BENEFIT CLAIM NUMBER	BEGIN DATE	GROSS AMOUNT	PAY PERIOD
	PAID BY SUPERCASE MEMBER		HOURLY <input type="checkbox"/> YES <input type="checkbox"/> NO	HRS PER PAY PERIOD	PAY PER HOUR
	NOTES				
NAME	EMP ID NUMBER	BENEFIT CLAIM NUMBER	BEGIN DATE	GROSS AMOUNT	PAY PERIOD
	PAID BY SUPERCASE MEMBER		HOURLY <input type="checkbox"/> YES <input type="checkbox"/> NO	HRS PER PAY PERIOD	PAY PER HOUR
	NOTES				
NAME	EMP ID NUMBER	BENEFIT CLAIM NUMBER	BEGIN DATE	GROSS AMOUNT	PAY PERIOD
	PAID BY SUPERCASE MEMBER		HOURLY <input type="checkbox"/> YES <input type="checkbox"/> NO	HRS PER PAY PERIOD	PAY PER HOUR
	NOTES				
NAME	EMP ID NUMBER	BENEFIT CLAIM NUMBER	BEGIN DATE	GROSS AMOUNT	PAY PERIOD
	PAID BY SUPERCASE MEMBER		HOURLY <input type="checkbox"/> YES <input type="checkbox"/> NO	HRS PER PAY PERIOD	PAY PER HOUR
	NOTES				
NOTES					

9. ARE ANY OF THE EU MEMBERS RESPONSIBLE FOR PAYING A SHELTER EXPENSE SUCH AS RENT, MORTGAGE PAYMENT, TAXES AND INSURANCE ON THE HOME, UTILITIES OR TELEPHONE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, EXPLAIN)							
TYPE (RENT, ELEC., GAS, ETC.)	AMOUNT	PAID BY	FREQUENCY	PRIMARY HEAT/COOL <input type="checkbox"/> YES <input type="checkbox"/> NO	LIHEAP <input type="checkbox"/> YES <input type="checkbox"/> NO		
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
NOTES							
10. DO ANY OF THE EU MEMBERS PAY CHILD SUPPORT OR ALIMONY TO OR FOR SOMEONE OUTSIDE THE HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)							
PAID BY	AMOUNT	PAID TO	NOTES				
11. DATE OF BIRTH INFORMATION/VERIFICATION							
NAME	DOB	PARENTS MARRIED AT BIRTH <input type="checkbox"/> YES <input type="checkbox"/> NO	MOTHER MAIDEN NAME	FATHER	COUNTY/STATE OF BIRTH		
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
		<input type="checkbox"/> YES <input type="checkbox"/> NO					
12. MISSOURI STATE RESIDENCY MO RESIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO INTENDS TO REMAIN <input type="checkbox"/> YES <input type="checkbox"/> NO							
NOTES							
13. EDUCATIONAL INFORMATION							
NAME	STATUS	HIGHEST GRADE COMPLETED	DATE	DEGREE	SCHOOL NAME	TYPE	EXPECTED GRAD DATE
NOTES REGARDING STUDENT ELIGIBILITY							

14. ARE YOU AND ALL MEMBERS OF YOUR HOUSEHOLD UNITED STATES CITIZENS? <input type="checkbox"/> YES <input type="checkbox"/> NO LIST EACH INDIVIDUAL WHO DECLARES "NO" TO CITIZENSHIP AND COMPLETE SPONSOR INFORMATION. <input type="checkbox"/> DECLARES NO SPONSORS FOR ALL					
NAME	DATE OF ENTRY	STATUS	DOC TYPE	SPONSOR	AGREE TO CONTACT <input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
NOTES					
15. SPONSOR INFORMATION					
EU MEMBER NAME	SPONSOR NAME	LIVING <input type="checkbox"/> YES <input type="checkbox"/> NO	I-864 AFTER 12/18/97 <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTES	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
16. DECLARATION (PROVIDE EXPLANATION OF ANY DECLARATION QUESTION ANSWERED "YES" IN NOTES SECTION. EXPLAIN TO THE EU THAT A "YES" RESPONSE MAY RESULT IN A DISQUALIFICATION OF BENEFITS FOR THAT INDIVIDUAL.					
A.	Have you or any member of your household been convicted of buying or selling Food Stamp benefits of \$500 or more after 9-22-96? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
B.	Are you or any member of your household fleeing to avoid prosecution, custody, or jail for a crime (or attempted crime) that is a felony? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
C.	Are you or any member of your household violating a condition of probation or parole? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
D.	Are you or any member of your household receiving Food Stamp/Temporary Assistance benefits under another identity or as a member of another household or in another state? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
E.	Have you or any member of your household been convicted in a Federal or State court of a felony committed after 8/22/96 related to illegal possession, use, or distribution of a controlled substance? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
F.	Have you or any member of your household ever been convicted of fraudulently receiving duplicate Food Stamp/Temporary Assistance benefits in any State after 9-22-96? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
G.	Have you or any member of your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives after 9-22-96? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
H.	Have you or any member of your household ever been convicted of trading Food Stamp benefits for drugs after 9-22-96? If yes, who?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
NOTES					

17. DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST PERSON AND DISABILITY)				
NAME	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABILITY BEGAN	REASON	
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
18. JOB QUIT/REDUCED HOURS				
HAS ANYONE IN YOUR HOUSEHOLD AGE 16 TO 60 QUIT A JOB IN THE LAST 60 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
HAS ANYONE IN YOUR HOUSEHOLD AGE 16 TO 60 REDUCED HOURS WORKED IN THE LAST 60 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, EXPLAIN (WORK REDUCTION DOES NOT APPLY TO TEMPORARY ASSISTANCE.)				
19. EMPLOYMENT ASSESSMENT (FS WORK REGISTRATION)				
DESCRIBE AVAILABILITY FOR METP. INCLUDE POSSIBLE EXEMPTIONS OR EXCLUSIONS. (IE: PUBLIC TRANSPORTATION IS AVAILABLE, NEEDED IN HOME TO CARE FOR ELDERLY MOTHER, PREGNANT ETC.)				
20. WORK REQUIREMENT (FS - ABAWD) IS THERE A CHILD IN THE HOME UNDER 18? <input type="checkbox"/> YES <input type="checkbox"/> NO				
NAME OF ABAWD	HAS DISQUALIFIED INDIVIDUAL WORKED OR PARTICIPATED IN A WORK PROGRAM FOR 80 HOURS IN A 30-DAY PERIOD?		NOTES	
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
21. TEEN PARENT				
NAME	ADULT SUPERVISED SETTING <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPERVISED BY	GOOD CAUSE	NOTES
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
	<input type="checkbox"/> YES <input type="checkbox"/> NO			
22. NONCUSTODIAL/ABSENT PARENT INFORMATION: LIST NAMES(S) OF THE CHILD(REN) FOR WHOM YOU ARE APPLYING, AND THE NAME(S) OF THE OTHER PARENT(S)				
CHILD'S NAME	CHILD'S MOTHER	CATE OF BIRTH AND/OR SSN (IF KNOWN)	CHILD'S FATHER	DATE OF BIRTH AND/OR SSN (IF KNOWN)
23. ASSIGNMENT/REFERRAL				
I/WE WILL COOPERATE WITH THE FAMILY SUPPORT DIVISION CHILD SUPPORT IN ESTABLISHING PATERNITY AND IN SECURING SUPPORT, BY IDENTIFYING (NAMING) THE NON-CUSTODIAL ABSENT PARENT(S), BY PROVIDING INFORMATION TO HELP LOCATE THE ABSENT PARENT(S), AND BY HELPING, AS NECESSARY, TO OBTAIN CASH SUPPORT PAYMENTS FROM THE ABSENT PARENT(S). <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> GOOD CAUSE				
EXPLAIN GOOD CAUSE				

24. TEMPORARY ASSISTANCE INFORMATION				
SUBSIDIZED HOUSING <input type="checkbox"/> NONE <input type="checkbox"/> PUBLIC HOUSING <input type="checkbox"/> RENT SUBSIDY				
INFORMATION NEEDED FOR DEEMING THE INCOME OF A STEPPARENT OR MINOR PARENT'S PARENT(S)				
DEEMED PERSON	INCOME	NUMBER OF PERSONS	NOTES	
NOTES				
25. DO ANY OF THE EU MEMBERS OWN A CAR, TRUCK, MOTORCYCLE, OR RECREATIONAL VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, DESCRIBE)				
YEAR/MAKE/MODEL	FMV	DEBT	USAGE	OWNERS
26. DO ANY OF THE EU MEMBERS OWN ANY REAL PROPERTY/MOBILE HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)				
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
NOTES				
27. DO ANY OF THE EU MEMBERS OWN BUSINESS EQUIPMENT, MACHINERY, FARM MACHINERY, TOOLS, FARM GRAIN OR PRODUCE IN STORAGE, MOTOR HOME, CAMPER/TRAILER, BOAT/MOTOR, AIRCRAFT, OR BURIAL LOTS? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)				
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
DESCRIPTION	FMV	DEBT	USAGE	OWNERS, NOTES
	ACCESS <input type="checkbox"/> YES <input type="checkbox"/> NO	SIGNIFICANT RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO	GOOD FAITH EFFORT TO SELL <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. HAVE ANY OF THE EU MEMBERS SOLD OR GIVEN AWAY ANY MONEY, VEHICLES, PROPERTY, OR OTHER RESOURCES IN THE PAST THREE MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)				
DESCRIPTION	DATE TRANSFERRED	VALUE	NOTES	

29. DO ANY OF THE EU MEMBERS OWN OR ARE THEY PURCHASING LIFE INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
DESCRIPTION	CSV	OWNERS, NOTES			
NOTES					
30. DOES ANYONE LISTED PAY SOMEONE TO CARE FOR A CHILD OR A DISABLED INDIVIDUAL, HAVE TRANSPORTATION TO AND FROM THE PROVIDER, OR PAY DEPENDENT CARE EXPENSES FOR SOMEONE OUTSIDE THE EU, IN ORDER TO SEEK, ACCEPT, OR CONTINUE EMPLOYMENT, ATTEND TRAINING, OR GO TO SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
PERSON PAYING CHILD CARE	CHILD/ADULT	REASON	AMOUNT	FREQUENCY	MONTHLY MILES
31. TEMPORARY ASSISTANCE WORK REQUIREMENTS					
NAME	WORK REQ IND	EXEMPT REASON	EXCLUDE REASON	EXTENSION REASON	RE-EVALUATION DATE
32. DOES ANYONE HAVE MEDICAL EXPENSES SUCH AS INSURANCE, COPAYS, DENTURES, OFFICE VISITS, GLASSES/CONTACTS, HOSPITAL BILLS, ALERT SYSTEMS, SMI, MEDICARE SUPP/PART D, HEARING AIDS, IN-HOME/ATTENDANT CARE, MILEAGE, LODGING, MEDICAL SUPPLIES, MEDICINE, EXPENSES FOR A FORMER EU MEMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, LIST)					
NAME	DESCRIPTION	AMOUNT	FREQUENCY	MONTHLY MILES	
33. EXPEDITED DETERMINATION <input type="checkbox"/> EXPEDITED <input type="checkbox"/> NOT EXPEDITED					
34. IF EXPENSES EXCEED INCOME AND RESOURCES FOR FOOD STAMP BENEFITS, DISCUSS AND EXPLAIN MANAGEMENT.					
35. TA DRUG SCREENING					
MISSOURI REGULATIONS FOR THE TEMPORARY ASSISTANCE PROGRAM REQUIRE FSD TO ASK THE FOLLOWING QUESTION REGARDING ILLEGAL DRUG USE. HOW MANY TIMES IN THE PAST YEAR HAVE YOU USED AN ILLEGAL DRUG OR USED A PRESCRIPTION MEDICATION FOR NON-MEDICAL REASONS?					
<input type="checkbox"/> DECLINE TO DECLARE <input type="checkbox"/> ZERO TIMES <input type="checkbox"/> ONE TO FIVE TIMES <input type="checkbox"/> SIX TO NINE TIMES <input type="checkbox"/> TEN OR MORE TIMES					
36. TA DRUG TREATMENT					

SOME INDIVIDUALS APPROVED FOR TA WILL BE REQUIRED TO SUBMIT TO DRUG TESTING, BASED ON THE SCREENING QUESTION. TA PARTICIPANTS REQUIRED TO SUBMIT TO DRUG TESTING MAY WAIVE THE TESTING REQUIREMENT AND BE REFERRED TO A SUBSTANCE ABUSE TREATMENT PROGRAM WITH THE DEPARTMENT OF MENTAL HEALTH (DMH). IF YOU ARE REQUIRED TO SUBMIT TO A DRUG TEST, DO YOU WISH TO WAIVE THE TEST AND BE REFERRED TO DMH FOR SUBSTANCE ABUSE TREATMENT?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

ADDITIONAL NOTES – DISCUSS OUTSTANDING VERIFICATIONS

ELIGIBILITY SPECIALIST SIGNATURE

ELIGIBILITY SPECIALIST ID

DATE