

TIERS Data Collection Worksheet

Advisor Name	Office
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Section I			
Case Name	Case No.	Action Type <input type="checkbox"/> Application <input type="checkbox"/> Redetermination	File Date
Type of Interview <input type="checkbox"/> Telephone <input type="checkbox"/> Office	Interview Date	Person Interviewed	ID of Person Interviewed
Physical and/or Mailing Address		Area Code and Telephone No.	Notice Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Both
Programs Applied For <input type="checkbox"/> SNAP <input type="checkbox"/> TANF Medicaid: <input type="checkbox"/> PW <input type="checkbox"/> Adult <input type="checkbox"/> Children		Authorized Representative	

Section II							
Individual Information							
Individual	Applying for Aid	DOB	SSN If None, Date Applied For	Ethnicity	SSCN/Railroad Retirement	HHSC Employee Y/N If Yes, Employee No.	State Employee
1.	Yes No						Yes No
2.	Yes No						Yes No
3.	Yes No						Yes No
4.	Yes No						Yes No
5.	Yes No						Yes No

Case Comments (Document special circumstances such as special accommodations, temporary absence, anticipated changes, etc.)

Section III							
Relationship							
Individual	Relationship to the Head of Household/ Verification	Purchase/ Prepare Together	If Yes, Physically Able to Purchase/ Prepare Together	Fills Parental Role	Tax Dependent	Provides Care For	Provides Support For
1.	Head of Household	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
2.		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3.		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
4.		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
5.		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Case Comments

Section IV							
Education							
Individual	Graduate	Grad Date or Expected Date	Highest Grade	Enrollment status Full/half	HS Diploma or GED Required?	Name of School	Type of Institution
1.	Yes No				Yes No		
2.	Yes No				Yes No		
3.	Yes No				Yes No		
4.	Yes No				Yes No		
5.	Yes No				Yes No		

Education					
Individual	Training Program or Work Study (hrs per week)	Able to Work	Child Care	Meets Attendance Requirements	Verification
1.		Yes No	Yes No	Yes No	
2.		Yes No	Yes No	Yes No	
3.		Yes No	Yes No	Yes No	
4.		Yes No	Yes No	Yes No	
5.		Yes No	Yes No	Yes No	

Case Comments

Section V							
Living Arrangement							
Individual	Living Arrangement		GLA Drug/Alcohol Treatment Center				
	Type Ex. At Home	Verification	Name of Facility	Meets Nonprofit and State Certified	Individual Receives Half Meals	Lives in Treatment Center	Treatment Center Authorized to Receive SNAP, Licensed by TCADA
1.				Yes No	Yes No	Yes No	Yes No
2.				Yes No	Yes No	Yes No	Yes No
3.				Yes No	Yes No	Yes No	Yes No
4.				Yes No	Yes No	Yes No	Yes No
5.				Yes No	Yes No	Yes No	Yes No

Case Comments

Section VI						
Individual Demographics						
Individual	ID No./Verification	Marital Status	U.S. Citizen	Alien Status (USCIS Document No., Date of Entry, Annotation, etc.)	Volag or Sponsor? (Organization, Name, etc.)	Migrant or Seasonal Farm Worker
1.			Yes No		Yes No	Yes No
2.			Yes No		Yes No	Yes No
3.			Yes No		Yes No	Yes No
4.			Yes No		Yes No	Yes No
5.			Yes No		Yes No	Yes No

Individual Demographics						
Individual	State Moved From/Date	Type/Date Benefits Ended	Texas Resident	Verification of Physical Address	Plan to Remain in Texas	Pursued All Legally Entitled Income/ Resources
1.			Yes No		Yes No	Yes No
2.			Yes No		Yes No	Yes No
3.			Yes No		Yes No	Yes No
4.			Yes No		Yes No	Yes No
5.			Yes No		Yes No	Yes No

Individual Demographics										
Individual	Active Duty	Start/ End Dates	Verification	Honorable Discharge	Veteran, Child or Spouse	VA Incapacity	Deceased	Felony Conviction After 8/22/96	Date of Offense	Fugitive, Probation/ Parole Violation
1.	Yes No			Yes No		Yes No	Yes No	Yes No		Yes No
2.	Yes No			Yes No		Yes No	Yes No	Yes No		Yes No
3.	Yes No			Yes No		Yes No	Yes No	Yes No		Yes No
4.	Yes No			Yes No		Yes No	Yes No	Yes No		Yes No
5.	Yes No			Yes No		Yes No	Yes No	Yes No		Yes No

Case Comments

Section VII				
Individual Questions				
List Disabled Individual	List Disability Details	List Disability Benefits Received (RSDI/SSI, VA, etc.)	List Name of Foster Child in Home/Included in EDG	List Newborn, Include Details (DOB, Mother Eligible at Time of Birth)

List Pregnant Individual	Pregnancy Start Date, Due/Termination Date	Exempt From Work?	Number of Births Expected	Verification
		Yes No		
		Yes No		

Case Comments: (Document name and address of unborn child's father)

Section VIII

Individual	Parenting Skills Required	Imm. Records Required	THSteps Required	PRA Required Y/N Date Signed	TPR Y/N If Yes, Provide TPR Details (Refer to H1039)	Workforce Orientation Y/N Pended/Date Attended	ESP Exemption (Document Reason and Verification)	PWE	Tier Level Details Ed. Level and Work History Mos (18 mos. or more, 6-17 mos, < 6 mos)
1.	Yes No	Yes No	Yes No					Yes No	
2.	Yes No	Yes No	Yes No					Yes No	
3.	Yes No	Yes No	Yes No					Yes No	
4.	Yes No	Yes No	Yes No					Yes No	

Case Comments

Non-Financial/ABAWD

Individual	ABAWD Information			Regaining Eligibility Information		
	Fit to Participate at Least 20 Hrs/Wk	Meets the Work Requirement	Verification	Meets 20 Hrs/Wk or Other Exemption	Work 80 Hrs or More in Any 30 Day Period	Verification
1.	Yes No	Yes No		Yes No	Yes No	
2.	Yes No	Yes No		Yes No	Yes No	
3.	Yes No	Yes No		Yes No	Yes No	

Case Comments

Non-Financial/Finger Imaging

Individual	Imaged	VUN	Date Finger Image Taken	Exempt From Requirement/Good Cause	Reason/ Exemption Code
1.	Yes No			Yes No	
2.	Yes No			Yes No	
3.	Yes No			Yes No	

Case Comments

Section IX						
Absent Parent (AP) Information						
Child's Name	AP's name	SSN	DOB	Deceased	Perjury Statement	Volunteer
1.				Yes No	Yes No	Yes No
2.				Yes No	Yes No	Yes No
3.				Yes No	Yes No	Yes No

AP Information					
Child's Name	Address	Employer	Court Order Child Support	Current Marital Status to AP	Good Cause
1.			Yes No		Yes No
2.			Yes No		Yes No
3.			Yes No		Yes No

Case Comments

Section X							
Resources							
Individual	Vehicle	Liquid (Cash, CD, Bank Account, Stocks, Bonds)	Real Property	Lump Sum Payment	Burial Resource	Misc. Government Payment	Transfer Property
1.							
2.							
3.							
4.							
5.							

Case Comments

Section XI							
Income							
Individual	Source (Employer, RSDI, Child Support, etc.)	Address	Pay Frequency	Received Dates	Amount	Verification Source	Date Income Began/Changed
1.							
2.							
3.							
4.							
5.							

Case Comments

Section XII

Expenses/Deductions

Individual	Expense (Rent, Utilities, Dependent Care, Medical Expense, Child Support, Alimony, etc.)	Person or Entity Expense is Paid to and the Address and/or Telephone No.	Frequency	Dates Paid	Amount	Verification Source
1.						
2.						
3.						
4.						
5.						

Case Comments

Section XIII

Streamlined Reporting

Is any individual aware of a change that would make the household or individual ineligible in the next six months?.....Yes No

Section XIV

Management

Expense	Monthly Amount	Paid	Documentation/Explanation of Management
1. Shelter			
2. Utilities			
3. Telephone			
4. Food			
5. Car Payments			
6. Car Maintenance			
7. Charge Accounts			
8. Transportation			
9. Cable			
10. Furniture/Appliance			
11. Loan			
12. Insurance			
13. Child Care			
14. Medical Expense			
15. Other			

Total Income	\$
- Total Expense	\$
Difference	\$

Use the SNAP Budget Worksheet to determine eligibility and benefit amount for expedited issuances. Follow existing procedures for issuing benefits via the Administrative Terminal (AT).

Section XV		
Net Income Determination	Budget No. 1	Budget No. 2
1. Total Gross Income		
2. Earned Inc. Ded. (20% of Earned Income)		
3. Remaining Farm Loss (if NA, enter 0)		
4. Standard Deduction		
5. Allowable Medical Costs (Actual or Standard)		
6. Homeless Shelter Standard		
7. Monthly Dependent Care Costs		
8. Child Support Paid to/for Non-Household Members		
9. Total Deductions (add 2, 3, 4, 5, 6, 7 and 8)		
10. Adjusted Gross Income (Item 1 minus 9)		
11. Shelter Expenses:		
a. Housing		
b. Utility or Telephone Standard		
c. Expedited Only –	(1) Gas	
Actual Utilities	(2) Electric	
	(3) Water/Sewage	
	(4) Other (explain)	
d. Total Shelter Costs		
e. Subtract 50% Adjusted Gross Income		
f. Total Excess Shelter Costs		
12. Maximum Excess Shelter (if applicable)		
13. Net Income (Item 10 minus 11f. or 12)		
14. Rounded Net Income		

15. Is household eligible based on net income?..... Yes No NA

16. Number of Certified Members

17. Monthly Allotment (TWH C1431)

18. Prorated Allotment (if applicable) (TWH C1432)

19. Months Covered by first budget month

_____ through _____

20. Months Covered by second budget month

_____ through _____