MONTHLY SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) REPORT FOR RESIDENTIAL FACILITIES

Facility Name: ___________________________ **Report Mo/YR:** ____________

Address: ___________________________ **Facility FNS #:** ____________

City: ___________________________

Resident Name	SNAP Case Number	Date Arrived	Date Left	Benefit Month

SNAP Transactions

Date	$$ Withdrawn	Date	$$ Returned

Page Totals	$	$
Other Page(s) Total	$	$
Report Month Totals	$	$

I certify that this is an accurate report of all SNAP transactions completed by this facility.

Signature: ___________________________ Date ___ /_____ /_____

(responsible facility official)

Title: ___________________________ Phone: (_______)____________

Report due by 15th of each month about the PRIOR month. Send Report to:

Department of Health and Social Services
Division of Public Assistance
Program Integrity & Analysis Section
P.O. Box 110640
Juneau, AK 99811-0640
FAX: 907-465-3651