# *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| | | | | | | Date | $$ Withdrawn | Date | $$ Returned |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| | **Page Totals** | | | | | $ | | $ | |
| | **Other Page(s) Totals** | | | | | $ | | $ | |
| | **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, Alaska 99811-0640
FAX: 907-465-3651