QC 6VCS
Rev. 12/25
08/18 Issue Obsolete

Louisiana Department of Health
Economic Stability
Supplemental Nutrition Assistance Program
SNAP – Quality Control

_____
_____
_____
_____

QUALITY CONTROL VERIFICATION OF CHILD SUPPORT

Date: _____

Case Name: _____

QC Review Number: _____

QC ES Specialist: _____

The above-named person has given consent for release of information requested below in order to complete a federally mandated quality control review. Please complete this form and return it to the address or fax number listed above by _____. Thank you for your cooperation.

PLEASE COMPLETE THE FOLLOWING:

1. Do you give money directly to the household? ☐ Yes ☐ No If yes, please indicate the dates given below. Also, please fill out the amounts and dates you have given money from _____ to _____ .

Amount	Date Given	Amount	Date Given	Amount	Date Given
$ _____	_____	$ _____	_____	$ _____	_____
$ _____	_____	$ _____	_____	$ _____	_____
$ _____	_____	$ _____	_____	$ _____	_____
$ _____	_____	$ _____	_____	$ _____	_____

*Please continue on back of this sheet if more space is needed.

2. Do you pay any of the household's expenses directly to someone other than the client? ☐ Yes ☐ No
   If yes, what date did you begin paying directly? _____
   Also, how often do you pay these expenses directly? _____
   Please list what expenses you pay or purchase directly for this household:
   (Example: rent, electricity, gas, phone, medical, personal items, insurance, etc.)

   _____
   _____

Signature: _____ Date: _____

Print your name: _____

Address: _____

Telephone number where you can be reached during the day: _____