GROWER'S STATEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
SFN 1076 (1-2023)

Clear Fields

Return By	
Grower's Name	Date

GROWER: Read, fill out and sign on reverse side:

This **MIGRANT HOUSEHOLD** has applied for SNAP benefits. To determine eligibility we request the following information:

1. Name of **MIGRANT HOUSEHOLD**
2. County of Residence of **MIGRANT HOUSEHOLD**
3. Date of **HOUSEHOLD'S** Arrival
4. Number of Adults in Above **HOUSEHOLD** Working in Field
5. Number of Workers in the **HOUSEHOLD**
6. Was money advanced to the **HOUSEHOLD** for travel? ☐ No ☐ Yes-How much?
7. Will this be deducted from their wages? ☐ No ☐ Yes-When?
8. Date Employment is Expected to Begin:
9. Date Employment is Expected to End

LIST ONLY THE AMOUNT OF WAGES THAT CAN BE ANTICIPATED WITH REASONABLE CERTAINTY, BOTH AS TO AMOUNT AND DATE OF RECEIPT, TAKING INTO ACCOUNT VARIABILITY OF WEATHER, WEED PRESSURE, ETC. IF THE EXACT AMOUNT OF INCOME IS NOT KNOWN, LIST ONLY THAT PORTION OF IT THAT CAN BE ANTICIPATED WITH REASONABLE CERTAINTY.

10. a. The **HOUSEHOLD** was/will be given an advance(s) that was/will be subtracted from wages to be earned by the **HOUSEHOLD** at a later date.

☐ No ☐ Yes - Answer Below:

Amount of the Advance	Date Advance Was Will be Given

b. The **HOUSEHOLD** Was Will be Paid as Follows:

- ☐ Upon Completion of Work
- ☐ Weekly in the Amount of _____
- ☐ Bi-Weekly in the Amount of _____
- ☐ Monthly in the Amount of _____

11. Acres

a. Number of Acres to be Thinned by this **HOUSEHOLD**	Rate per Acre
b. Number of Acres to be Weeded by this **HOUSEHOLD**	Rate per Acre
c. Number of Times These Acres are to be Weeded by this **HOUSEHOLD**	Rate per Acre

12. If more than one **HOUSEHOLD** is working for you, answer the following:

Total Acres	Total Number of Workers

Additional Information/Comments

NORTH DAKOTA CENTURY CODE, SECTION 34-14-02, EFFECTIVE AUGUST 1, 1995:

Every employer shall pay all wages due to employees at least once each calendar month on regular agreed paydays designated in advance by the employer, in lawful money of the United States or with checks on banks convenient to the place of employment. If an employee participates in a direct deposit program, that employee's employer shall deposit the employee's wages into the financial institution of the employee's choice. An employer may not require an employee to directly deposit the employee's wages into a financial institution.

I understand that the information provided on this form does not constitute a contract for services and that I completed this form correctly to the best of my knowledge. Entiendo que la informacion proveida en esta forma no constituye un contrato para servicios y he llenado esta forms correctamente segun mi entendimiento.	
Signature of Grower	Date

I understand that the information provided on this form does not constitute a contract for services. Entiendo que la informacion proveida en esta forma no constiutye un contrato para servicios.	
Signature of Employee	Date

Return your signed and dated form to your local human service zone office

OR

Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506

OR FAX: (701)-328-1006

OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005
Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones