

Mail this form to: Department of Social Services, S.D. Sales Tax on Food Refund Program, 700 Governors Drive, Pierre, SD 57501-2291. If you have any questions, call toll-free 1-866-674-0543, or (605) 773-4105. You may also fax this form to 605-773-7183.

Step 2: Continue listing all members of your household who share food costs with you.

First Name	Middle Name	Last Name	Social Security Number	Birth Date	Race	Sex	*LS	Relationship to You
First Name	Middle Name	Last Name	Social Security Number	Birth Date	Race	Sex	*LS	Relationship to You
First Name	Middle Name	Last Name	Social Security Number	Birth Date	Race	Sex	*LS	Relationship to You

If you have more names, please list the information on a separate sheet of paper and attach to the application form.

Step 3: Continue listing income received for past 12 months.

Person with Income: _____	Income Type: _____	Gross Income for 12 Months: \$ _____ ; or complete below:						
List Gross income for each month:	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____
(if income is received for only a few months, list income for only the months it was received)	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____
	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____

Person with Income: _____	Income Type: _____	Gross Income for 12 Months: \$ _____ ; or complete below:						
List Gross income for each month:	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____
(if income is received for only a few months, list income for only the months it was received)	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____
	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____	Month: _____	Amount: \$ _____

If you have more income, please list the information on a separate sheet of paper and send with the application form.

Applicant's Rights:

- No person can be denied benefits because of race, color, national origin, gender, religion, age, disability, or political belief. To file a complaint of discrimination write: DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501-5070 or call: (605) 773-3305.
- As an applicant for assistance, you or your authorized representative, have the right to a fair hearing if you disagree with any decision regarding your application. You must request the fair hearing within 60 days from the date you received a written notice for the Sales Tax on Food Refund Program. You may request a fair hearing by calling 1-866-674-0543, (605) 773-4105, or writing the Department of Social Services, Sales Tax on Food Refund Program, 700 Governors Drive, Pierre, SD 57501-2291 or writing the Office of Administrative Hearings, Department of Social Services, 700 Governors Drive, Pierre, SD 57501-2291.