

# Change Report Form

NAME		CASE NUMBER			
STREET ADDRESS		CITY		STATE	ZIP CODE
WORKER NAME				WORKER PHONE NUMBER	

## Purpose

This form is to report changes to your county agency or tribal office which may affect your eligibility or benefit level.

## Instructions

Fill out this form only if you have changes to report. If you get cash assistance or health care, **report any change within 10 days**. If you get Supplemental Nutrition Assistance Program (SNAP) benefits, **report changes by the 10th of the month following the month of the change**. For example, if a change happens in March, you must report the change by April 10. You may also call your worker to report a change. If you don't know whether to report a change, call your worker.

**Note – Return completed form to your county agency or tribal office**

STREET ADDRESS	CITY	STATE	ZIP CODE
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Remember to sign and date. Use a separate sheet if you need more room. If you do not know your county agency or tribal office address, call your worker.

## Change in address (you must send proof of changes)

Check here if this is not applicable

I/we moved to:

COUNTY MOVED TO	COUNTY MOVED FROM		
ADDRESS	NEW PHONE NUMBER		
CITY	STATE	ZIP CODE	DATE MOVED

Have you moved onto a reservation?  Yes  No      Have you moved from a reservation?  Yes  No

## Change(s) in people in my home

Check here if this is not applicable      **Total number of people now in my home:** \_\_\_\_\_

NAME	RELATIONSHIP TO YOU	MOVED <input type="radio"/> Yes <input type="radio"/> No	MARRIED <input type="checkbox"/>	DIED <input type="checkbox"/>	BORN <input type="checkbox"/>	DATE OF CHANGE	DATE OF BIRTH
SOCIAL SECURITY NUMBER	HAS INCOME? <input type="radio"/> Yes <input type="radio"/> No	SOURCE OF INCOME?			HOW OFTEN PAID?		
NAME	RELATIONSHIP TO YOU	MOVED <input type="radio"/> Yes <input type="radio"/> No	MARRIED <input type="checkbox"/>	DIED <input type="checkbox"/>	BORN <input type="checkbox"/>	DATE OF CHANGE	DATE OF BIRTH
SOCIAL SECURITY NUMBER	HAS INCOME? <input type="radio"/> Yes <input type="radio"/> No	SOURCE OF INCOME?			HOW OFTEN PAID?		

Do any of the new people in your home buy, fix or eat meals with you?  Yes  No

If yes, name(s) \_\_\_\_\_

## Change in income (types of proof: pay stubs, stop work form, etc.)

Check here if this is not applicable

### Started work

NAME		DATE STARTED	DATE OF FIRST PAYCHECK	
EMPLOYER'S NAME	CHILD OR ADULT CARE NEEDED <input type="radio"/> Yes <input type="radio"/> No	\$ PER HOUR	HOW OFTEN PAID	HOURS WORKED PER WEEK

### Stopped work

NAME		DATE LAST WORKED	DATE LAST CHECK RECEIVED
REASON FOR STOP WORK		EMPLOYER'S NAME	

### Change in pay or work hours

NAME		REASON		
CHANGE IN WAGES <input type="radio"/> Increase <input type="radio"/> Decrease	NEW PAY RATE PER HOUR	DATE OF FIRST PAY DATE WITH CHANGE IN WAGES		
CHANGE IN HOURS <input type="radio"/> Increase <input type="radio"/> Decrease	NEW HOURS PER WEEK	DATE HOURS CHANGED	FIRST PAY DATE WITH CHANGE	

### Other income

NAME OF FAMILY MEMBER	START DATE	AMOUNT	END DATE
<input type="checkbox"/> Social Security <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> VA <input type="checkbox"/> Retirement <input type="checkbox"/> Child Support <input type="checkbox"/> Personal Injury <input type="checkbox"/> School, grants, etc. <input type="checkbox"/> Other _____			

## Change in shelter costs (types of proof: receipt, bill)

Check here if this is not applicable

### Housing costs

<input type="radio"/> Rent <input type="radio"/> Mortgage	NEW AMOUNT	DATE OF CHANGE	INSURANCE	TAXES
ARE COSTS SHARED OR SUBSIDIZED? <input type="radio"/> Yes <input type="radio"/> No	IF YES, TOTAL COST		HOW MUCH DO YOU PAY?	
CHANGES HAVE OCCURRED IN THE FOLLOWING AREAS <input type="checkbox"/> Phone <input type="checkbox"/> Electricity <input type="checkbox"/> Heat <input type="checkbox"/> Air Conditioning <input type="checkbox"/> Garbage/Trash <input type="checkbox"/> Water/Sewer				

Do you get Low Income Home Energy Assistance Program (LIHEAP) funds?    Yes    No

## Change in savings or property (types of proof: bank statement, property statement)

Cash and health care only  Check here if this is not applicable

<input type="checkbox"/> Savings/checking, certificates of deposit, IRAs, etc.					<input type="radio"/> Open \$ _____		<input type="radio"/> Closed	
<input type="checkbox"/> Land or buildings	PLACE		<input type="radio"/> Bought	AMOUNT PAID/RECEIVED	DATE PAID/RECEIVED			
			<input type="radio"/> Sold					

## Change in vehicles (types of proof: bill of sale, title certificate)

Cash and health care only  Check here if this is not applicable

Report if you bought, sold, traded, were given or gave away any vehicles (examples: cars, vans, trucks, motorcycles, off-road vehicles, boats).					
<input type="checkbox"/> Bought by or given to someone in your home			<input type="checkbox"/> Sold, transferred, or given away by someone in your home		
HOUSEHOLD MEMBER		DATE OF TRANSACTION	MONEY RECEIVED IF SOLD		
TYPE OF VEHICLE	MAKE	MODEL	YEAR	VALUE	

## Other changes

Check here if this is not applicable

Changes have occurred in the following areas:				
<input type="checkbox"/> Medical insurance	<input type="checkbox"/> Medical costs	<input type="checkbox"/> Legal action	<input type="checkbox"/> Child or adult care costs	
<input type="checkbox"/> Other _____				
EXPLAIN				
<input type="checkbox"/> Received Social Security card for _____ on _____ SSN is _____				

The changes I report here  will or  will not continue next month.

**Penalty warning:** If you get cash or SNAP benefits, you must follow the rules listed below. The state may bar household members who break any of these rules from the cash or SNAP programs. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from cash assistance for breaking the rules may count toward your 60-month lifetime limit for the Minnesota Family Investment Program. Convictions for public assistance fraud may result in a fine or jail time, or both.

- Do not give false information or hide information to get or continue to get cash or SNAP benefits.
- Do not trade or sell SNAP benefits or Electronic Benefit Transfer (EBT) access card(s).
- Do not use cash or SNAP benefits to buy ineligible items, such as alcohol and tobacco.
- Do not use someone else's EBT access card(s) to get cash or SNAP benefits for your household.

If you get cash or SNAP benefits and give false information or hide information about your identity and/or residence to get multiple benefits for the same period of time, you may be barred from receiving benefits for 10 years.

**Acknowledgment:** I know what I reported here. It is a true and correct statement of every material point. If I give incorrect information, the county may prosecute me for fraud under state law. The county may also try me for perjury under state law.

SIGNATURE	PHONE NUMBER	DATE

## Civil Rights Notice

**Discrimination is against the law.** The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

## Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator  
 Minnesota Department of Human Services  
 Equal Opportunity and Access Division  
 P.O. Box 64997  
 St. Paul, MN 55164-0997  
 651-431-3040 (voice) or use your preferred relay service

### Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights  
 Freeman Building, 625 North Robert Street  
 St. Paul, MN 55155  
 651-539-1100 (voice)  
 1-800-657-3704 (toll free)  
 711 or 1-800-627-3529 (MN Relay)  
 651-296-9042 (fax)  
 Info.MDHR@state.mn.us (email)

### U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights  
 200 Independence Avenue SW, Room 509F  
 HHH Building  
 Washington, DC 20201  
 1-800-368-1019 (voice)  
 1-800-537-7697 (TDD)  
 Complaint Portal:  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዩን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သျှ်ဟ်သးဘၣ်တက့ၢ်. ဝဲန့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤကလိၤလၢတၢ်ကကျိးထံဝဲဒၣ်လၢ် တီလၢ်မိတခါဆံၤန့ၢ်,သံကွၢ်ဘၣ်ပုၤဂ့ၢ်ဝီဆပုၤမၤစၢၤတၢ်လၢန့ၢ်မ့တ မ့ၢ်ကိးဘၣ် 1-844-217-3549 တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາຍ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອ ໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທໂປຣໂທ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)



For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)