

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 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 <input type="radio"/> Sold	AMOUNT PAID/RECEIVED	DATE PAID/RECEIVED

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
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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.

የስተውሉ፡ ይህንን ዶክመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆኑ፡ የጉዳዮች 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.

ဟ်သ့ဟ်သးဘဉ်တက့ၢ်. ဖဲန့ၢ်လိာ်ဘဉ်တၢ်မၤစၢၤကလီၤလၢတၢ်ကကျိးထံဝဲဒၣ်လၢ် တီလၢ်မိတခါအံၤန့ၣ်,သံကွၢ်ဘဉ်ပုၤဂ့ၢ်ဝီအပုၤမၤစၢၤတၢ်လၢန့ၢ်မ့တ မ့ၢ်ကိးဘဉ် 1-844-217-3549 တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໂປ 1-888-487-8251.

Hubachiisa. Dokumentiin kum 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, hawlwaadeenkaaga 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.

DAI (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)