Medical Assistance/TANF Change Report Form

Your Name                                                                             Benefits Specialist

Address                                                                                  Address -

City, State, Zip Code                                                              City, State, Zip Code –

Phone Number                                                                 Phone Number –

Changes must be reported to your Department of Social Services Benefits Specialist as soon as you become aware of them, but no later than 10 days from the date of the change. You can report changes by coming into your local Department of Social Services Office, calling your Benefits Specialist or you can use this form to report the changes.

✓ CHECK THE SECTIONS THAT HAVE CHANGED

For Medical Assistance and/or Temporary Assistance for Needy Families (TANF) Programs:

☐ Someone moved into your home (complete section below)

Name of Person                                                                         Indicate if Requesting Medicaid Assistance and/or Temporary Assistance for Needy Families (TANF)

First                      Middle Initial         Last

DOB                     Gender                     SSN

Medical Assistance? YES ☐ NO ☐

TANF? YES ☐ NO ☐

Does this person plan to file a federal income tax return next year? YES ☐ NO ☐

If yes, please answer questions A - C

A. Will this person file jointly with a spouse? YES ☐ NO ☐

If yes, name of the spouse

B. Will this person claim any dependents on your tax return? YES ☐ NO ☐

If yes, list name(s) of dependents

C. Will this person be claimed as a dependent on someone’s tax return? YES ☐ NO ☐

If yes, name of tax filer ________________________________ Relationship to tax filer _____________________

☐ Someone moved out of your home (list person below):

Name of Person                                                                         Date Left

First                      Middle Initial         Last

☐ Employment income changed. Check reason(s) below:

☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours

☐ Other: Describe change

Provide employer information below:

Employer Name, Address and Phone Number | Wages/Tips (before taxes) | Average hours worked each WEEK

$___________________________

☐ Weekly ☐ Twice a month

☐ Monthly ☐ Every 2 Weeks ☐ Yearly

Case #: ___________________   Section: __________
If self-employed, describe type of work and the change in income below:

[Blank]

☐ Other income changed. Complete all that apply

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount</th>
<th>How often received?</th>
<th>Source of Income</th>
<th>Amount</th>
<th>How often received?</th>
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<tbody>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td>Alimony Received</td>
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<td>Pensions</td>
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<td>Net Farming/fishing</td>
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<td>Social Security</td>
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<td>Net rental/royalty</td>
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<td>Retirement</td>
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<td>Other income type</td>
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</tbody>
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☐ Someone in the household is pregnant. If checked, complete questions below:
Name of person that is pregnant: ______________________ Due Date _______ Number of babies ________

☐ Someone gave birth to a child. If checked, complete questions below:
Date of birth: ______________ Name of newborn: ___________________________ Gender: __________

For Medical Assistance Only:

☐ Health insurance started, stopped, or company changed?
List the policy # ___________________________ Co. Name/address: ___________________________
Describe the change: ____________________________________________

For TANF Only:

✔ CHECK THE SECTION(S) THAT HAVE CHANGED, EXPLAIN & ATTACH PROOF:

☐ Bank accounts/resources changed. Describe new accounts, increased amounts in existing accounts, etc.
________________________________________________________

☐ Bought, sold, traded, or gave away vehicles (cars, trucks, boats, etc). Describe the change:
________________________________________________________

☐ The amount you pay for child support payments started, stopped, or changed. Describe who the payment is for, who it is paid to, and the change in payment:
________________________________________________________

☐ School attendance changed. Provide name, change that occurred, and date of occurrence:
________________________________________________________

I understand that the information on this form is subject to verification by Federal, State and local officials to determine that such information on this form is correct and complete. If any information is found to be incorrect, benefits may be reduced or terminated and I may be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this report form has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information.

________________________________________________________
Signature                                                                                      Date

Additional Comments: _______________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________