Case #: _____ Section: __1__

DSS-EA-310 05/2017

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	_____

If self-employed, describe type of work and the change in income below:

☐ **Other income changed. Complete all that apply**

Source of Income	Amount	How often received?	Source of Income	Amount	How often received?
Unemployment			Alimony Received		
Pensions			Net Farming/fishing		
Social Security			Net rental/royalty		
Retirement Accounts			Other income type		

☐ **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: _____

_____

_____