DHS Office:

DHS Office Address:

Case Name:
Case Number:
Date:

**STATE OF MICHIGAN**
**Department of Human Services**

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

Name:

Address:

# CHANGE REPORT

Use this form to **report changes about anyone in your home within 10 days** of the time you learn of them (For earned income, within 10 days of receiving of your first payment.) If you cannot mail this form, report the change by calling your DHS specialist.

## 1. PERSONS IN YOUR HOME

List anyone who: • Was Born--Enter newborn's date of birth _____

• Died • Got Married or Divorced • Moved In or Out • Began or Ended a Pregnancy • Entered or Left a Nursing Home
• Is Temporarily Away From Your Home.

| PERSON'S NAME | RELATIONSHIP TO YOU | DATE OF BIRTH | WHAT WAS THE CHANGE? | DATE OF CHANGE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## 2. HOUSEHOLD INCOME

**Did anyone:** start working, have a change in rate of pay, change employers, have a change in the number of hours worked per week of more than 5 hours since last report that will continue for more than one month, stop working? **Did anyone:** start or stop getting Social Security, a pension, UCB, child support or other unearned income. Did the household's gross unearned income go up or down by more than $50 per month since your last reported change? If receiving Medicaid only (except for Healthy Kids), you must report a change in gross monthly unearned income of more than $25.

**ATTACH a written statement SIGNED BY EMPLOYER, listing your work schedule (days and times) if you use day care and your work schedule has changed.**

**SEND PROOF OF INCOME: Include your name and case number on it so we may return it to you.**

| PERSON WITH INCOME CHANGE | TYPE OF INCOME | DID INCOME START, STOP OR CHANGE? | IS THE CHANGE EXPECTED TO CONTINUE? (Yes/No) | NUMBER OF EXPECTED HOURS OF WORK PER WEEK | HAS WORK SCHEDULE CHANGED? | AMOUNT RECEIVED? | HOW OFTEN IS INCOME RECEIVED? (Weekly, Bi-Weekly, Monthly, etc.) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

## 3. EDUCATION OR WORK-RELATED ACTIVITIES

Did anyone participate in an approved employment-related activity, such as: a work participation program, high school completion, GED or college, etc. **ATTACH NEW CLASS SCHEDULE TO THIS FORM IF CHANGED.**

| LIST PERSON IN ACTIVITY | TYPE OF ACTIVITY | HAS CLASS SCHEDULE CHANGED? (Yes/No) | DID ACTIVITY START, STOP, OR CHANGE? | NUMBER OF HOURS OF EXPECTED PARTICIPATION PER WEEK |
|---|---|---|---|---|
| | | | | |
| | | | | |

**over**

## 4. CHILD DAY CARE OR DISABLED ADULT CARE

Report any need for or change in child or disabled adult care such as changes in: need, days and times care is provided, provider changes, where care is provided, provider charges, etc. Do you receive help to pay for this care? ____ Yes ____ No

| PERSON RECEIVING CARE | AGE | REASON FOR CARE(Work, School, Training, Medical/Social) | DATE OF CHANGE? | NAME OF THE PROVIDER | PROVIDER ID NUMBER |
|---|---|---|---|---|---|
| a. | | | | | |
| b. | | | | | |
| c. | | | | | |
| d. | | | | | |

| PERSON RECEIVING CARE (List the same person as above) | DAYS AND TIMES CARE IS PROVIDED | IS CARE PROVIDED IN CHILD'S HOME? | IS PROVIDER RELATED TO THE CHILD | RATE CHARGED AND HOW OFTEN (Hourly, Daily, Weekly, etc.) | |
|---|---|---|---|---|---|
| a. | | | | $ | per q |
| b. | | | | $ | per |
| c. | | | | $ | per |
| d. | | | | $ | per |

## 5. ASSETS

Report if anyone has opened or closed any accounts such as: bank, retirement or CD, or bought, sold, transferred, given away, or received any other asset such as: land, cars, and other vehicles, boats, life insurance, investments, lawsuit settlements or any other property.

| WHAT CHANGED? | PLEASE EXPLAIN THE CHANGE |
|---|---|
| | |
| | |
| | |

## 6. OTHER CHANGES

Report if anyone has a change such as: address, rent, mortgage, taxes, insurance (home or health), utility costs, child support paid, medical expenses, school attendance.

| PERSON WITH CHANGE | DATE OF CHANGE | PLEASE EXPLAIN THE CHANGE |
|---|---|---|
| | | |
| | | |
| | | |

**7. Do you expect the changes you reported to continue next month?** ☐ Yes ☐ No
**If no, please explain below.**

I understand that the information I provide on this report form may result in changes in my assistance, including reducing the amount of my checks (Cash Assistance, employment-related services and/or Child Development and Care), Food Assistance benefits and medical assistance, or closing my case. I understand that such changes may be made without advance notice. **I am aware that, if I give false information which causes me to receive assistance I am not entitled to, or more assistance than I am entitled to, I can be prosecuted for fraud.** I must report all changes in my situation within 10 days of learning of the change, or for earned income, within 10 days of the start date of employment.

**I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

| Client's Signature or Mark | Date | Client's Telephone Number |
|---|---|---|
| Signature of Other Person Completing Form or Witness | Date | |

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

**AUTHORITY:** Act 280 of 1939, Food Stamp Act of 1977 **COMPLETION:** Voluntary **PENALTY:** Loss of eligibility for assistance benefits