

## Change Report Form

Use this form to report changes in your household or family. The Division of Public Assistance needs to know about these changes so we can determine your continued eligibility for assistance and benefit amount. Changes must be reported within 10 days of when you know of the change (*5 days when a child leaves the home, if you get Temporary Assistance*). Attach proof of the change if you have it.

**If your household only receives Food Stamp benefits, you only need to report when your household's income is more than your household's gross income limit**

\_\_\_\_\_  
Name Social Security # Home Phone Work Phone

Current Mailing Address \_\_\_\_\_

Which type of Public Assistance benefits do you receive?

Alaska Temporary Assistance  Food Stamps  Adult Public Assistance  Medicaid  CAMA

### Change in employment

Whose employment changed? \_\_\_\_\_

Date of the change \_\_\_\_\_  Job ended  Job Started  Job is Full-Time  Job is Part-Time

Employer's name \_\_\_\_\_ Employer's phone number \_\_\_\_\_

Hours per week \_\_\_\_\_ Rate of pay \$ \_\_\_\_\_ per hour OR \$ \_\_\_\_\_ per month

How often paid? \_\_\_\_\_ (weekly, bi-weekly, twice a month, monthly)

If this is a new job, when is the first check expected? \_\_\_\_\_

Do you expect this change in employment to last for the next couple of months? YES NO

Does this change make your household's income more than your Food Stamp gross income limit? YES NO

### Change in unearned income more than \$50 a month (*Child support, unemployment, social security, worker's compensation, veterans' benefits, etc.*)

Who receives it? \_\_\_\_\_ Amount \$ \_\_\_\_\_

When is it received? \_\_\_\_\_ What is the source of this income? \_\_\_\_\_

Does this change make your household's income more than your Food Stamp gross income limit? YES NO

### Someone moved in or out of the household

Who moved? \_\_\_\_\_ Moved in or moved out? IN OUT When? \_\_\_\_\_

Relationship to you \_\_\_\_\_ Does this person buy and prepare food with you? YES NO

Do you want this person included in your benefits? YES NO If yes, provide the following information:

Social Security # \_\_\_\_\_ US Citizen? YES NO Legal immigrant? YES NO

State of Alaska  
Department of Health and Social Services  
Division of Public Assistance

**Moved or got a new mailing address**

New home address \_\_\_\_\_

New mailing address \_\_\_\_\_

Date of move \_\_\_\_\_ What are your new housing costs? \_\_\_\_\_

What utilities are you responsible for paying? \_\_\_\_\_

**Someone got a vehicle** (*cars, trucks, boats, motorcycles, RVs, ATVs, snowmobiles, etc.*)

Who? \_\_\_\_\_ When? \_\_\_\_\_

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

Value \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_

How will this vehicle be used? \_\_\_\_\_

Did this replace a vehicle? YES NO If yes, explain: \_\_\_\_\_

**Household now has a combined total of \$2000 or more in cash and money in bank accounts**

Explain: \_\_\_\_\_

**Change in legal obligation to pay child support**

Who in your household pays child support? \_\_\_\_\_ Amount per month \$ \_\_\_\_\_

**Change in medical coverage** (*only for Medical Assistance recipients*)

Name(s) \_\_\_\_\_

Did coverage start or stop? START STOP Effective date of change \_\_\_\_\_

Insurance company name and address \_\_\_\_\_

**Other Changes – Please explain**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Sign Below**

The information I have entered on this form is correct and complete to the best of my knowledge. I understand that proof of the changes I reported might be required.

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_