

Joe Lombardo
Governor

Laura Rich
Director



DEPARTMENT OF HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

Serving Nevada. Supporting Community. Building Futures.



Robert H. Thompson
Administrator

CHANGE REPORT FORM

YOU MUST REPORT CHANGES TO US WITHIN 10 DAYS AFTER THE CHANGE HAPPENS IF YOU ARE RECEIVING SNAP BENEFITS AND BY THE 5TH OF THE FOLLOWING MONTH FOR TANF AND/OR MEDICAL ASSISTANCE.

Fill in the spaces below. (You can write an explanation on a separate sheet of paper.)

PLEASE PROVIDE PROOF OF THE CHANGES.

| | | | |
|---|-------|---------------------|------------|
| NAME | | SOCIAL SECURITY NO. | |
| ADDRESS | APT # | HOME PHONE | CELL PHONE |
| CITY/ZIP CODE | | E-MAIL | |
| Is this a new address? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| MAILING ADDRESS (If different) | | | |

PEOPLE CHANGES: Did someone Move in move out or have a baby? Please provide details below.

| NAME | DATE MOVED IN OR OUT | DATE OF BIRTH | SOCIAL SECURITY NO. | RELATIONSHIP |
|------|----------------------|---------------|---------------------|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Is the member moving in a tax filer? YES NO

Is the member moving in a tax dependent? YES NO

If yes, who claims this member as a tax dependent?

INCOME AND JOB CHANGES

Did someone get a new job? YES NO

Who? _____ **When?** _____

| | |
|---|------------------------|
| Place of Employment | Hours worked per week |
| Hourly Rate | Date of First Paycheck |
| Day of the week paid | Pay Frequency |
| Are tips received? <input type="checkbox"/> YES <input type="checkbox"/> NO | Amount per month |
| Medical insurance available? <input type="checkbox"/> YES <input type="checkbox"/> NO | Effective Date |

Did someone end a job? YES NO

Who? _____ **When?** _____

| | |
|---|------------------------|
| Place of Employment | Hours worked per week |
| Hourly Rate | Date of First Paycheck |
| Day of the week paid | Pay Frequency |
| Are tips received? <input type="checkbox"/> YES <input type="checkbox"/> NO | Amount per month |
| Medical insurance available? <input type="checkbox"/> YES <input type="checkbox"/> NO | Effective Date |

Did someone change work hours or pay? YES NO

Who? _____ **When?** _____

| | |
|---|------------------------|
| Place of Employment | Hours worked per week |
| Hourly Rate | Date of First Paycheck |
| Day of the week paid | Pay Frequency |
| Are tips received? <input type="checkbox"/> YES <input type="checkbox"/> NO | Amount per month |
| Medical insurance available? <input type="checkbox"/> YES <input type="checkbox"/> NO | Effective Date |



OTHER INCOME CHANGES (Unemployment benefits, Social Security benefits, SSI, disability, child support, etc.)

Explain type of income and change:

How much is received each month? \$

Who receives this income?

EXPENSE CHANGES

Your SNAP deductions are based on the expenses you report and provide proof of. If sufficient proof is not submitted with this change report form, your case will be pended for the required verification. If proof of an expense is not provided, the expense cannot be allowed.

If you report a change for an approved SNAP expense during your certification period, proof of the expense must be provided. If you report a change for an approved SNAP expense during your recertification, proof of the expense must be provided.

If proof is not provided, the expense will not be used in your eligibility determination.

New rent/mortgage payment? \$

Do you pay utility bills? YES NO

Child Care Expenses? \$

Medical expenses for the elderly (60+) or disabled?

Does anyone pay part of these expenses? Explain:

New child support you are ordered to pay? \$

RESOURCE CHANGES

You must report any changes in resources (checking/savings accounts, bonds, home/land, boat, life insurance, vehicles, etc.). Include specific information about the opening, closing, purchasing, selling of, or changes to resources. Explain:

OTHER CHANGES NOT LISTED ABOVE

i.e. Pregnancy

PLEASE READ AND SIGN: "I understand the penalty for hiding information or giving false information. I understand that I must repay the value of any benefits I get because I did not report changes or failed to report changes timely. I understand I may be disqualified from getting benefits. I can be fined or prosecuted or both if I do not tell the truth. I agree to provide proof of any changes if asked to do so. My answers on this form are true, correct and complete to the best of my knowledge."

Client Signature

Print Name

Date

Telephone Number

PROVIDE PROOF OF CHANGES

IF WE CHANGE YOUR BENEFITS WE WILL SEND YOU A NOTICE.

