Arkansas Department of Human Services
Division of County Operations
CHANGE REPORT

County Office Address & Phone Number

IF YOU NEED THIS INFORMATION IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT THE DHS COUNTY OFFICE.
(Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español.)

You may call or email the DHS County Office at the phone number or webmail address shown to report changes for your TEA, Medicaid, or SNAP case(s). Please use the toll-free number provided if the DHS County Office number is long distance.

Name: _____ **Your Social Security Number:** _____

Check all that you receive: ☐ TEA ☐ Medicaid ☐ SNAP

Enter your Address: _____
_____

Phone # _____
Hearing Impaired Phone # _____
E-mail address _____

Is this a new address? ☐ **YES** ☐ **NO** **NOTE: If you have moved, you must complete Section 5.**
If your address changes, you should report your new address to us at once or you may not receive important correspondence from DHS.

INSTRUCTIONS: You may use this form to report the following changes in your household's circumstances.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ONLY:

- You must report changes in your total household income when it goes up or down by more than $50 per month. (*You do not have to report changes in your TEA benefit amount*.)
- You must report increases in your household's cash and savings if the total cash and savings of all household members now equal or exceed $2,000 or more.

TEA AND MEDICAID PROGRAMS ONLY

- You must report any change in income you receive regardless of the amount received or how often you expect to receive it.
- For Medicaid, you must report increases in your household's savings if the total amounts to $1,000 or more.
- For TEA Cash Assistance, you must report increases in your household's savings if the total amount exceeds $3,000.

The following changes must be reported in the following Programs: SNAP, Medicaid and TEA Cash Assistance

- You must report changes in any source of income.
- You must report cars, or other licensed vehicles if anyone in your home get one.
- You must report changes in the number of people in your household.
- You must report if you move to a new residence.
- If you move, you must report your new rent (or mortgage) and utility costs.
- You should always report any address changes even if you do not move.

NOTICE TO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM HOUSEHOLDS SUBJECT TO SEMI-ANNUAL REPORTING AND/OR LIMITED REPORTING: See the ADDENDUM for an explanation of your reporting requirements. You may use this *Change Report* to report if your income begins to exceed the limit for your household size or if certain people in your home begin working less than 20 hours per week. Those are the changes that you are required to report. However, you may use this form to report a change if you would like to do so. YOU OR ANYONE IN YOUR HOME WHO GETS CASH ASSISTANCE OR MEDICAID MUST CONTINUE TO REPORT CHANGES AS SHOWN ABOVE. IF THESE CHANGES AFFECT YOUR SNAP CASE, WE WILL LET YOU KNOW.

SECTION 1 - DID YOUR INCOME CHANGE?

New Income: Complete this section if you or anyone in your household started working or began getting income from a new source. Report the income of new members here.

Name of Household Member	Source of New Income (Company, Agency, Person, etc.)	Date Income Was First Received	Amount
			$

Income Stopped: Complete this section if you or anyone in your household stopped working or getting income from any source.

Name of Household Member	Source of Income That Stopped (Company, Agency, Person, etc.)	Date Income Was Last Received	Reason Income Stopped

Income Went Up or Down: Complete this section if income received by you or anyone else in your household changed.

Name of Household Member	Source of Income That Changed (Company, Agency, Person, etc.)	Date Income Changed	New Amount	How Often Received?
			$	

Required Proof: You must send proof of the change in income. Send award letters, check stubs, cash receipts, or any other documentation that shows the new amount of income, and for income that stopped, the last date paid. If your income from work changed, send proof of all cash, checks, etc. received in the last 30 days.

SECTION 2 - DID YOUR SAVINGS INCREASE?

You must tell us if the total amount of money that you or anyone else in your household has in liquid resources (cash, savings accounts, checking accounts, stocks, bonds, etc) increases to $2,000 if you receive SNAP benefits, to $1,000 or more if you receive Medicaid, or to more than $3,000 if you receive TEA cash assistance. This includes all accounts with the name of a household member on the account even if the money belongs to someone else.

State the current amount of your liquid resources. $_____

SECTION 3 - DID YOU GET A NEW VEHICLE?

If you or anyone in your household purchased, leases, or was given a car, truck, boat, camper, motorcycle or other vehicle, you must report the make, model and year of the new vehicle. This includes both licensed and unlicensed vehicles.					If a vehicle was sold or traded at the same time, you may wish to tell us the make, model, and year of the vehicle that was sold or traded.		
Make	**Model**	**Year**	**Licensed**	**Value**	**Make**	**Model**	**Year**
			YES ☐ NO ☐	$			

SECTION 4 - DID YOUR HOUSEHOLD COMPOSITION CHANGE?

If a member of your household moved out or passed away, you must complete this section. (Use a sheet of paper if you need more room to report.)

Name of Member Who is NO Longer in Home	Date Member Left Home	Social Security Number	Date of Birth	State Reason Member is NO Longer in Home

If someone moved into your home or if a member of your household had a baby, you must complete this section. (Use a sheet of paper if you need more room to report.) Each new household member must declare a social security number and/or citizenship status before he or she is allowed to receive SNAP benefits. Check below to indicate citizenship status. Also, you must complete the information on page 3 of this form.

Name of New Household Member	Date Member Entered Home	Social Security Number	Date of Birth	Relationship	U.S. Citizen	Legal Alien	Other

Are new members currently receiving SNAP, Medicaid, and/or TEA cash assistance? **YES ☐ NO ☐**

If yes, who is receiving benefits? _____

What benefits do they receive? _____

Where are they getting benefits? _____

SECTION 5 - SNAP HOUSEHOLDS ONLY - DID YOU MOVE TO A NEW RESIDENCE?

Check here if you moved to a new residence: ☐

Enter new rent or mortgage payment here: $_____
Enter insurance on home here: $_____
(If not included in payment)
Enter annual real estate taxes here: $_____
(If not included in payment)
List your new utility costs:
Heating fuel (Butane, natural gas, etc.) $_____
Electricity $_____ Water/Sewer $_____
Telephone $_____ Garbage Pickup $_____
Other $_____ - Explain _____

Check here if your address changed: ☐

If yes, give your new address:
_____
_____
Home Phone_____
Message Phone _____

Will you be using an air conditioner? **YES** ☐ **NO** ☐
How will you be heating your home?

Will anyone be paying part of your shelter costs?
YES ☐ **NO** ☐ If yes, who? _____

NOTE*: We use your utility expenses to determine your SNAP benefit amount. Usually, you may choose to use a utility standard or your actual verified utility costs only at application. Once you have chosen between the standard and actual costs, you may not switch to the other option until your next application. Contact your worker if you need more information.*

SECTION 6 - DID YOUR DEPENDENT CARE COSTS CHANGE?

Dependent care costs are payments for the care of a child or a disabled or elderly adult to allow someone in the household to work, look for work, or attend school or a training course. You are allowed, but not required, to report changes in dependent care costs.

Name of Person Who Pays this Cost	Name of Person Who is Paid	New Amount Paid	How Often Paid?
		$	

SECTION 7 - SNAP HOUSEHOLDS ONLY - DID THE MEDICAL EXPENSES OF AGED AND/OR DISABLED MEMBERS CHANGE?

We can deduct the medical expenses of household members who are age 60 or older or who are receiving disability benefits including: 1) social security disability, 2) SSI, 3) VA benefits paid for a permanent and total disability, or 4) permanent disability payments from a state or federal agency. (This includes charges for doctors, dentists, hospitals, Medicare, Medipak, other health insurance, prescription drugs*, dentures, hearing aids, glasses, attendants or nurses, transportation for medical care, and many other medical costs.) You are allowed, but not required, to report changes in medical expenses. If you choose to report a change in medical expenses, you must send proof of the new amount.

Name of Person With Medical Costs	Type of Expense	New Amount Paid	How Often is this Payment Due?

* You may wish to provide a printout from the drugstore or a list of the prescription drugs you take each month.

SECTION 8 - DID SOMEONE START PAYING CHILD SUPPORT?

Report here if you or anyone else in your household began paying child support to someone living outside your home.

Who pays child support?

To whom is support paid? Name _____
Address_____
_____
Telephone_____

How much do they pay? $
How often do they pay? _____

Are the child support payments court ordered? **YES** ☐ **NO** ☐

SOCIAL SECURITY NUMBERS (SSNs)

Households must provide or apply for an SSN for each household member who will be participating in Medicaid, Supplemental Nutrition Assistance Program, and TEA. Failure or refusal to provide for or to supply a social security number will result in that individual's disqualification.

PENALTY WARNINGS

Information on this form may be verified by Federal, State and local officials through computer matching. If any information is found to be incorrect, TEA, Medicaid, and/or SNAP benefits may be denied or stopped. Also, the applicant/recipient may be subject to criminal prosecution for knowingly providing incorrect information.

If you receive Medicaid and intentionally withhold information or misrepresent facts, you may be referred for criminal prosecution. For TEA, your family may be disqualified from the program for 1 year after the first violation, 2 years after the second violation, and permanently for more than two violations.

Any member of your household found to have intentionally broken SNAP rules will be disqualified from the Supplemental Nutrition Assistance Program for 1 year after the first violation, 2 years after the second violation and permanently after the third violation. The SNAP rules are:

- **Do not give false information or withhold information in order to get or to continue getting SNAP benefits**
- **Do not alter any authorization document to get SNAP benefits you are not eligible to receive.**
- **Do not use SNAP benefits to buy non-food items like alcoholic drinks, beer, or household supplies.**
- **Do not trade or sell SNAP benefits or allow unauthorized use of electronic benefit transfer (EBT) cards.**
- **Do not use someone else's EBT card for your household's benefit.**

Additional SNAP Violation Penalties:

- A court of law can ban anyone who intentionally breaks SNAP rules from getting SNAP benefits for an additional 18 months and can impose fines of up to $25,000, or send the violator to jail for up to 20 years or both.
- Any member of your household found to have made a fraudulent statement or representation about their identity or residence in order to get SNAP benefits in two locations in the same month may be disqualified for 10 years.
- No individual will be eligible to receive SNAP benefits as long as he or she is classified as a fleeing felon and/or a parole or probation violator.

The following individuals are permanently disqualified from receiving SNAP benefits:

- Violators found guilty in a court of law of buying or selling firearms, ammunition, explosives, or controlled substances in exchange for SNAP benefits.
- Violators found guilty in a court of law of trafficking SNAP benefits in excess of $500.
- Individuals who were found guilty of or who pled guilty or nolo contendere (no contest) to any state or federal offense classified as a felony by the law or jurisdiction involved, and which has as an element of the offense the distribution or manufacture of a controlled substance.

YOUR SIGNATURE

I understand the penalty for hiding or giving false information. I also understand I must repay extra SNAP, TEA, or Medicaid benefits that I receive because I did not fully report changes in my household. I agree to provide verification of any reported changes if I am asked to do so. As necessary to verify information contained in this report, I hereby authorize my employer(s), any banks, savings and loans, lending institutions, etc., and/or Federal or State agencies to release information about me or my circumstances to the Division of County Operations. I certify under penalty of perjury that my answers on this form are correct and complete to the best of my knowledge and that all household members are either U.S. citizens or aliens with legal immigration status.

Do you expect the changes that you reported will remain the same next month? YES ☐ NO ☐

If you answered no, please explain: _____

*** SIGN HERE _____ Today's Date _____**

IF YOUR BENEFITS CHANGE

We will use the information you provided on this form to determine if your household's benefits must change. If we must change your benefits, we will send you a notice explaining the action. If you do not agree with our decision, you may have a hearing to appeal the decision. Your notice will tell you how to ask for a hearing.

CIVIL RIGHTS

The Arkansas Department of Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, political affiliation, or veteran status. 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 in the Supplemental Nutrition Assistance Program, write: USDA, Director, Office of Civil Rights, Room, 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410. (Telephone and TDD for Hearing Impaired - 1-202-720-5964)