JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

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Administrator

CHANGE REPORT FORM

THE LAW SAYS 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.) You can mail or bring this report into the office.
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? ☐ YES ☐ 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? ☐ YES ☐ NO Amount per month _____
Medical insurance available? ☐ YES ☐ 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? ☐ YES ☐ NO Amount per month _____
Medical insurance available? ☐ YES ☐ 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? ☐ YES ☐ NO Amount per month _____
Medical insurance available? ☐ YES ☐ 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

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.