FOR OFFICE USE ONLY:
Case Number:_____ Date Received:_____
How Received: ☐Mail ☐Fax ☐Walk-In ☐Telephone ☐CWP
Received By: _____

MDHS
MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

# CHANGE REPORTING FORM

**Name: _____ Case Number: _____ Contact Number: _____**

To make a change to your case, please **ONLY** complete the section(s) that apply.

## NEW ADDRESS/PHONE NUMBER CHANGES

Home Address: _____ County: _____

If you are not registered to vote where you live now, would you like to register to vote? ☐ Yes (provide an application) ☐No

Mailing Address:

Cell Phone Number: _____

Home Phone Number:_____

Email Address: _____

Would you like to receive notices by email? ☐Yes ☐No

## INCOME CHANGES – Attach Verification

| Type of Income | Income | How Often Received | Total New Gross Per Pay Period | Name of Person Receiving Income Change |
|---|---|---|---|---|
| **CHECK ONE BOX ONLY**<br>☐Employment ☐Pension<br>☐Unemployment ☐Disability<br>☐Child Support ☐Cash Gift<br>☐Other_____ | **CHECK ONE BOX ONLY**<br>☐New ☐Stopped<br>☐Increase ☐Fired<br>☐Decrease ☐Quit<br>Date of change:_____ | **CHECK ONE BOX ONLY**<br>☐Daily ☐Semi-monthly<br>☐Biweekly<br>☐Weekly<br>☐Monthly | Amount<br>$<br>Hours per week employed | Last:_____<br>First:_____ |
| **CHECK ONE BOX ONLY**<br>☐Employment ☐Pension<br>☐Unemployment ☐Disability<br>☐Child Support ☐Cash Gift<br>☐Other_____ | **CHECK ONE BOX ONLY**<br>☐New ☐Stopped<br>☐Increase ☐Fired<br>☐Decrease ☐Quit<br>Date of change:_____ | **CHECK ONE BOX ONLY**<br>☐Daily ☐Semi-monthly<br>☐Biweekly<br>☐Weekly<br>☐Monthly | Amount<br>$<br>Hours per week employed | Last:_____<br>First:_____ |

## RESOURCE CHANGES – Attach Verification

Name of Person who Owns Resource

☐Cash $_____ ☐Stocks $_____ ☐Bonds $_____
☐Bank Accounts $_____ ☐Other $_____

Last:_____
First:_____

## EXPENSE CHANGES – Attach Verification

Name of Person Paying the Expense

☐Rent/Mortgage $_____ ☐Lot Rent $_____
***If paid separately from your mortgage:*** ☐Home Insurance $_____ ☐Property Taxes $_____
Has the expense: ☐Started ☐Stopped ☐Changed Date of change: ____/____/_____
How often billed: ☐Daily ☐Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Last:_____
First:_____

☐Medical $_____ (***Household member must be 60 or older or disabled to claim out of pocket medical expenses.)***
☐Drugs ☐Medical/Dental ☐Hospital Bills ☐Nursing Care ☐Medicare Premium ☐Transportation
☐Medical Supplies/Equipment ☐Eye Glasses/Contacts ☐Other Medical_____
Has the expense: ☐Started ☐Stopped ☐Changed Date of change: ____/____/_____
How often billed: ☐Daily ☐Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Last:_____
First:_____

☐Child Support $_____ (***Must be court ordered and paid outside of the household.)***
Has the expense: ☐Started ☐Stopped ☐Changed Date of change: ____/____/_____
How often billed: ☐Daily ☐Weekly ☐Biweekly ☐Semi-Monthly ☐Monthly

Last:_____
First:_____

☐Child Care $_____
Has the expense: ☐Started ☐Stopped ☐Changed Date of change: ____/____/_____
How often billed: ☐Daily ☐Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Last:_____
First:_____

☐Other _____ $_____
Has the expense: ☐Started ☐Stopped ☐Changed Date of change: ____/____/_____
How often billed: ☐Daily ☐ Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Last:_____
First:_____

Do you pay a heating and/or cooling expense? ☐Yes ☐No
If you are not billed a heating and/or cooling expense, list the amounts you are billed, if any, for the following:
Electricity $_____ Gas $_____ Water $_____ Phone $_____ Garbage $_____ Other $_____

**HOUSEHOLD MEMBER CHANGES – PENALTY WARNING: ***A Social Security Number (SSN) must be provided or applied for each person for whom assistance is requested per the Food and Nutrition Act of 2008. SSNs will be verified and used for Federal and State data matches, including but not limited to, Social Security, Internal Revenue Service, VA, MS Department of Employment Security, resource/income verifications, program disqualifications, and for collection of fraud debts. State and federal laws provide for fines, imprisonment or both for any person guilty of obtaining assistance to which he/she is not entitled by willfully withholding or giving false information. Information may be verified through collateral contacts when discrepancies are found. Alien status is subject to verification with United States Citizenship and Immigration Services (USCIS) and will require submission of certain information from this application to USCIS.

Only US citizens and qualified aliens are eligible for SNAP benefits. Any non-citizens or non-qualified aliens may be left out of your case. Such persons will not be reported to the Immigration and Customs Enforcement agency. Non-citizens included in your case will have eligibility determined under SNAP rules. The income and resources of all persons in your household will be considered in determining eligibility for persons included in your case.

| Name (Last, First) | Moved | | Relationship to Head of Household | Social Security Number *SEE DISCUSSION ABOVE | Date of Birth | Age | Sex | **Optional | | US Citizen Y or N |
|---|---|---|---|---|---|---|---|---|---|---|
| | In | Out | | | | | | Hispanic Y or N | *** Race Choose one or more | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

**Information pertaining to Ethnicity and Race is not required and will not be used in determining your eligibility or benefit level. This information will be used to determine how effective the program is in reaching the eligible population.
*** Race Codes **AL** – American Indian/Alaska Native; **AS**-Asian; **BL**-Black or African American; **HP**-Hawaiian or Other Pacific Islander; **WH**-White; **OT**-Other

**Has any person being added to your case been convicted of a drug-related felony that was committed since 08/22/96? ☐Yes ☐No**

**For each child whose mother and/or father is absent from the home, enter the information below:**

| Child's Name | Absent Parent's Name | Absent Parent's Address | Absent Parent's SSN | Absent Parent's | | |
|---|---|---|---|---|---|---|
| | | | | DOB | Race | Sex |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

By signing and dating this form, I am giving consent for the attendance records of the children identified on this application to be disclosed by the Mississippi Department of Education to the Mississippi Department of Human Services for use by the Department of Human Services to determine compliance with school attendance requirements of the Temporary Assistance for Needy Families (TANF) Program.

I certify that each person included in my household is a U.S. citizen or alien in lawful immigration status and that the information provided is true to the best of my knowledge. I give permission for the Department of Human Services to make a full review of my case and any necessary contacts to verify my statements. I know that I could be penalized if I knowingly give false information. I certify that I received the Rights and Responsibilities handout from this agency.

_____ _____
Signature of Applicant/Person Reporting the Change Date

_____ _____
Signature of Second Parent in TANF Date

_____ _____
Signature of Witness if Signed by Mark Date

****The signature of the TANF Payee and the Second Parent (if applicable) is required to add a household member to the TANF case.**

**USDA Nondiscrimination Statement**

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.