CHANGE REPORT FORM

For office use only.
Date Received:____________

CASE NUMBER

For Health Care Coverage

For Medicaid changes must be reported within ten days of when you become aware of them.
You may use this form to report changes by completing the section(s) that apply. If you have questions about how to fill out this form, call your County Social Services Office.

NAME:

ADDRESS:

RETURN COMPLETED FORM TO:
MORTON COUNTY SOCIAL SERVICES
200 2ND AVENUE NW
MANDAN ND 58554-3124
(701) 667-3395

REMEMBER TO ATTACH THE VERIFICATION FOR EVERY ITEM THAT HAS CHANGED. IF YOU DO NOT PROVIDE VERIFICATION, YOUR CASE MAY CLOSE.

☐ **CHECK IF CHANGE OF ADDRESS.**

DATE MOVED: ____________________ **LIST NEW ADDRESS:** ____________________

____

____

1. INCOME FROM EMPLOYMENT: List the gross earned income of everyone in your household from last month. Attach pay stubs or a signed statement from employer for all income received last month.

Household Member	Employer	Hours Worked Per Week	Hourly Pay	Last Month's Pay Before Taxes (Gross)	Amount of Tips	How Often Paid (Use Codes Below)	Day or Dates Paid (Use Codes Below)

How Often Paid Codes:
M - Monthly **2X - Twice a Month** **W - Weekly** **EX - Every Two Weeks** **Other, specify:** ____________

Day Paid Codes:
M - Monday **T - Tuesday** **W - Wednesday** **TH -Thursday** **F - Friday** **S - Saturday** **SU - Sunday**

2. Has anyone's employment stopped since your last report ☐ **Yes** ☐ **No** **If yes, list name of household member date employment stopped and date of last check:** ____________________ **Reason for termination** ☐ **Quit** ☐ **Fired** ☐ **Laid Off** ☐ **Other**

3. Has anyone's employment started since your last report ☐ **Yes** ☐ **No** **If yes, complete and verify:**

Who:____________________ **Date Started:** ____________________

Employer Name: ____________________ **Hours expected each pay period:**____________________

Rate of pay per hour: $____________ **How often paid:** ____________________

Date first check expected:____________ **Gross monthly wages: $**__________ **Tips: $**____________

NDDHS/SFN 378(REV.12-2008)

4. UNEARNED INCOME: List the type and the amount of unearned income received (such as Social Security, Unemployment Compensation, General Assistance, Child Support, etc.) last month and attach verification.

____

5. INCOME-EARNED/UNEARNED OR SELF EMPLOYMENT: Does anyone in your household expect an increase or decrease in income this month or next month? ☐ Yes ☐ No If yes, explain and provide verification of the expected change. ______________________________

6. HOUSEHOLD SIZE: Complete for anyone who has moved in or out of household.

HOUSEHOLD MEMBER	RELATIONSHIP	DATE MOVED IN	OUT	DATE OF BIRTH	SOCIAL SECURITY NUMBER

7. ASSETS: Families with minor children and pregnant women do not need to complete this section. Complete if anyone in the household had a change in assets, including anyone who moved into the household.

☐ Opened ☐ Closed an account. Type of account __________ Bank __________ $ __________

☐ Bought ☐ Sold ☐ Traded a vehicle. Make __________ Year ______ (If bought) Value $ ______ (If sold) $ ______

☐ Other changes in assets (properties, land, life insurance, etc.) ? Explain: ______________________________

____

8. CHILD SUPPORT: Did your legal obligation to pay child support change? ☐ Yes ☐ No If yes, explain, provide verification of the change and the amount you pay. ______________________________

9. CHILD CARE COSTS: List child care expenses from last month and provide verfication.

______________________________ ______________________________

______________________________ ______________________________

Do you expect changes in child care expenses next month? ☐ Yes ☐ No If yes, please explain and provide verification of expected change. ______________________________

10. HEALTH INSURANCE COVERAGE: Has any household member terminated Health Insurance coverage in the past six months? ☐ Yes ☐ No If yes, whom? ______________ Date Terminated? __________

Does a household member have medical coverage available from a current employer? ☐ Yes ☐ No

If yes, does the employer pay more than 50% of the premium? ☐ Yes ☐ No

If yes, list the name of the insurance. ______________________________

PENALTY WARNING

Changes you report can be checked by Federal, State and Local officials or by computer matches. Anything you may have told us that is incorrect may cause you to lose your Health Care Coverage benefits and/or subject you to criminal prosecution for knowingly providing false information. Do not give false information or hide information.

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I authorize the North Dakota Department of Human Services and the carrier(s) providing Healthy Steps insurance and the Caring for Children program to release to each other information regarding any services or benefits I receive under Healthy Steps, if my child is eligible, and any information needed to determine eligibility for the Caring for Children program. This authorization will remain valid until revoked in writing or until coverage ends. A copy of this authorization is as valid as the original.

I understand that the information I provide on this report may result in a change in my benefits, including a lower amount of benefits or no benefits. I understand that such changes may be made to my benefits without a timely notice. I certify under penalty of perjury that all the information that I have given on this report is true and correct to the best of my

____

SIGNATURE DATE PHONE NUMBER