Arkansas Department of Human Services
Division of County Operations
CHANGE REPORT

County Office Address & Phone Number

IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT
SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE at 1-855-372-1084.
Si necesita este formulario en Español, llame al 1-855-372-1084 y pida la versión en Español.
For TDD/TTY services, please contact Arkansas Relay at 1-800-285-1131 for English or 1-866-656-1842 for Spanish.
Para servicios TDD/TTY, comuníquese con Arkansas Relay al 1-800-285-1131 para inglés o al 1-866-656-1842 para español.

Name: _____ **Date of Birth:** _____

Case Number: _____ **Medicaid ID Number:** _____

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

Enter your Address: _____ **Phone:** _____

Hearing Impaired Phone: _____

_____ **Email:** _____

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 exceeds the limit for your household size. (*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 equals or exceeds $3,000 or more.

TEA AND HEALTHCARE 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 certain Medicaid programs, you must report increases in your household's savings if the total amounts to $2,000 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, Healthcare, 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 changes in your work activities or exemptions.
- 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 SIX (6) MONTH CERTIFICATIONS: 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 income stopped 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 $3,000 if you receive SNAP benefits, to $2,000 or more if you receive certain Healthcare assistance, 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 benefits. 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

Are new members currently receiving SNAP, Healthcare, and/or TEA cash assistance? **YES ☐ NO ☐**
If yes, who is receiving benefits? _____ Where are they getting benefits?_____
What benefits do they receive?_____
If **not receiving benefits, does this new member need health coverage? YES ☐ NO ☐**
Are any new members pregnant or were pregnant in the last 90 days? **YES ☐ NO ☐** If Yes, expected due date? _____ Number of babies expected in the pregnancy? _____
Do the new members plan to file a federal income tax return **NEXT YEAR**? **YES ☐ NO ☐**
Will they file jointly with a spouse? **YES ☐ NO ☐** If Yes, name of spouse:_____
Will they claim any dependents on their tax return? **YES ☐ NO ☐** If Yes, list names of dependents:_____
_____
Will the new household member be claimed as a dependent on someone's tax return? **YES ☐ NO ☐**
If Yes, please list the name of the tax filer: _____How are they related to the tax filer?_____

If the new household member is a minor child with an absent parent, please provide the absent parent's information:
First Name: _____ Last Name: _____ Social Security Number (SSN): _ _ _ - _ _ - _ _ _ _
Date of birth (mm/dd/yy) _ _ / _ _ / _ _ Address: _____
Phone: (_____) _____ Relationship to child: _____ Why is the parent absent from home? _____

You may claim to have good cause for refusing to provide absent parent information if you believe that it would not be in the best interest of you or your child(ren). You must provide evidence to support this good cause claim. Would you like to claim good cause? **YES ☐ NO ☐** If yes, please provide your good cause reason:_____
_____

SECTION 5 – HEALTH COVERAGE ONLY-ADDITIONAL MEMBER INFORMATION

Are any household members blind? **YES ☐ NO ☐** Name(s): _____

Are any household members disabled? **YES ☐ NO ☐** Name(s): _____

Does anyone need help with daily activities? **YES ☐ NO ☐** Name(s): _____

Is anyone in the household enrolled in health coverage? **YES ☐ NO ☐**

If yes, please state who has health coverage and the type of coverage that you have (Examples: Employer insurance, TRICARE, Medicare). If they have lost coverage in the last 6 months, please list the date the coverage was lost, and the reason it was lost. (Use a sheet of paper if you need more room to report.)

Person's name:	**Coverage Type:**	**Have you lost coverage in the last 6 months? YES ☐ NO ☐**
If yes, date coverage ended:	**Why was coverage lost?**	
Person's name:	**Coverage Type:**	**Have you lost coverage in the last 6 months? YES ☐ NO ☐**
If yes, date coverage ended:	**Why was coverage lost?**	

Are any members pregnant or were pregnant in the last 90 days? YES ☐ NO ☐

If **Yes**, name of household member(s): _____

When is the expected due date? (mm/dd/yy) _ _ / _ _ / _ _ Number of babies expected in the pregnancy: _____

Are any members currently active on Workers with Disabilities, AR Choices Waiver, or a DDS Waiver and would like to apply for any of the following services? Yes ☐ No ☐

Workers with Disabilities ☐ AR Choices Waiver ☐ DDS Waiver ☐

SECTION 6 - DID YOUR DEPENDENT CARE COSTS CHANGE?

Dependent care costs are payments for the care of a child or an adult aged 60 or older and/or an individual with a disability 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 INDIVIDUALS WITH DISABILITIES INCLUDED IN THE HOUSEHOLD 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?

How much do they pay? $

To whom is support paid? Name _____

Address _____

_____

Telephone _____

How often do they pay? _____

Are the child support payments court ordered?

YES ☐ NO ☐

SECTION 9 - 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: $_____

Landlord: _____ Government Subsidy $: _____

Enter insurance on home here: $ _____
(If not included in payment)

Enter annual real estate taxes here: $ _____
(If not included in payment)

Check here if your address changed: ☐

If yes, give your new address:

_____

_____

Home Phone _____

Message Phone _____

List your new utility costs:
Heating fuel (Butane, natural gas, etc.) $_____
Electricity $_____ Water/Sewer $_____
Telephone $_____ Garbage Pickup $_____
Other $_____ - Explain _____

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?
_____

SOCIAL SECURITY NUMBERS (SSNs)

Households must provide or apply for an SSN for each household member who will be participating in Healthcare, 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, Healthcare, 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 Healthcare 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 $250,000, imprisoned 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 Healthcare 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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.
Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or

2. **fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.
Under the Department of Human Services (DHS) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Department of Human Services Office of Security and Compliance at 501-682-6003.

You may also file a complaint of discrimination by contacting the DHS Office of Security and Compliance, P.O. Box 1437 – Slot S101 Little Rock, AR 72203-1437 or call (501) 682-6003 or fax (501) 682-8646.

VOTER REGISTRATION

Would you like to register to vote or change your voter registration address? YES ☐ NO ☐
If you marked yes, please complete the attached Voter Registration application and return it to your local DHS office or mail to the address listed on the form.

PLEASE PRINT AND USE BLACK INK TO COMPLETE

Rev. 1-24-19

ARKANSAS VOTER REGISTRATION APPLICATION

Check all that apply:
____ **This is a new registration.**
____ **This is a name change.**
____ **This is an address change.**
____ **This is a party change.**

Office Use Only

Assigned ID

1	Mr. Mrs. Miss Ms. — Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name		
2	Address Where You Live (See Section "C" Below) (Rural addresses must draw map.)	Apt. or Lot#	City/Town	County	State	ZIP Code
3	Address Where You Receive Mail If Different From Above	Apt. or Lot#	City/Town	County	State	ZIP Code

4 Date of Birth ____/____/____ (Month / Day / Year)

5 Home & Work Phone Numbers (Optional) **(H)** **(W)**

6 Party Affiliation (Optional)

7 E-mail Address (Optional)

8 Have you ever voted in a federal election in this State? D Yes D No

9 ID Number - Check the applicable box and provide the appropriate number.
D Arkansas Driver's license number ____
D **If you do not have a driver's license provide the last 4 digits of social security number** ____
D I have neither a driver's license nor social security number.

10
(A) Are you a citizen of the United States of America and an Arkansas resident? D Yes D No
(B) Will you be eighteen (18) years of age or older on or before election day? D Yes D No
(C) Are you presently adjudged mentally incompetent by a court of competent jurisdiction? D Yes D No
(D) Have you ever been convicted of a felony without your sentence having been discharged or pardoned? D Yes D No
If you checked No in response to either questions A or B, do not complete this form.
If you checked Yes in response to either questions C or D, do not complete this form.

Signature of elector - Please sign full name or put mark.

The information I have provided is true to the best of my knowledge. I do not claim the right to vote in another county or state. If I have provided false information, I may be subject to a fine of up to $10,000 and/or imprisonment of up to 10 years under state and federal laws.

11 Date: ____/____/____ (Month / Day / Year)

If applicant is unable to sign his/her name, provide name, address and phone number of the person providing assistance:

Name ____ Address: ____

City: ____ State: ____ Phone#: ____

Please complete the sections below if:

- You were previously registered in another county or state, or
- You wish to change the name or address on your current registration.

MAIL REGISTRANTS: PLEASE SEE SECTION D.

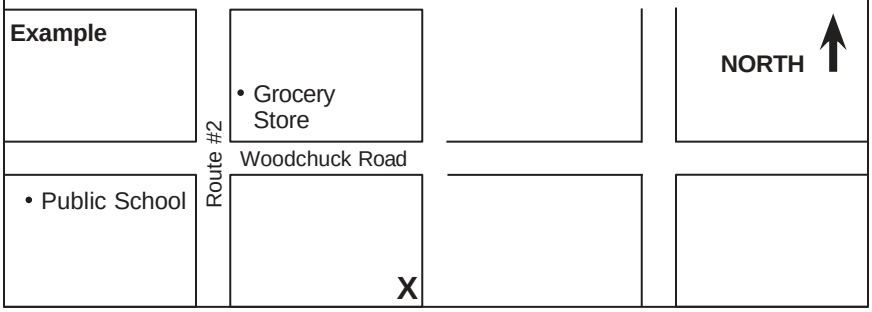
Agency Code (For Official Use Only)

Date of Birth ____/____/____ (Month / Day / Year)

A	Mr. Mrs. Miss Ms. — Previous Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name		
B	Previous House Number and Street Name	Apt. or Lot#	City/Town	County	State	ZIP Code

If you live in a rural area but do not have a house or street number, or if you have no address, please show on the map where you live.

C
- Write in the names of the crossroads (or streets) nearest where you live.
- Draw an "X" to show where you live.
- Use a dot to show any schools, churches, stores or other landmarks near where you live and write the name of the landmark.



D

IDENTIFICATION REQUIREMENTS

IMPORTANT: Applicants will be required to verify their registration when voting in person or by absentee ballot by providing a required document or identification card as provided in Arkansas Constitution, Amendment 51, Section 13. If your voter registration application form is submitted by mail and you are registering for the first time, and you do not have a valid Arkansas driver's license number or social security number, in order to avoid the additional identification requirements upon voting for the first time you must submit with the mailed registration form: (a) a current and valid photo identification; or (b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Arkansas Secretary of State
ATTN: Voter Registration
P.O. BOX 8111
Little Rock, Arkansas 72203-8111

From: _____

_____

_____

First Class Postage Required

Deadline Information

To qualify to vote in the next election, you must apply to register to vote 30 days before the election. If you mail this form, it must be postmarked by that date. You may also present it to a voter registration agency representative by that date. If you miss the deadline you will not be registered in time to vote in that election. ***Please don't delay. Make sure your vote counts.***

If you are qualified and the information on your form is complete, you will be notified of your voting precinct by your local County Clerk.

To Mail

Fold form on middle perforation, remove plastic strip, seal at bottom, stamp and mail.

Questions?
Call your local County Clerk
or
Arkansas Secretary of State
John Thurston
Elections Division – Voter Services
1-800-482-1127

Contact your County Clerk if you have not received confirmation of this application within two weeks.