Department of Public Health and Social Services

Division of Public Welfare ● Bureau of Economic Security
123 Chalan Kareta, Mangilao, Guam 96913-6304

CHANGE REPORT FORM

For Supplemental Nutrition Assistance Program (SNAP formerly Food Stamps) / Cash Assistance / Medical Assistance

PLEASE READ THE FOLLOWING:
You must report change(s) that may affect your benefits and provide the necessary verification/documentation for the change(s). If you do not provide verification/documentation, your case may be closed.
All changes must be reported within 10 days of the date the change becomes known to the household.
You may use this form to report changes by completing the section(s) that **apply.** After completing the form, you may drop it off at the center of your district. Or, you may place the form in the drop box located at these offices, or mail the form to the address shown above. If you have any questions about how to fill out this form, or where to drop off the document, you may contact any of the Bureau of Economic Security (BES) offices: Central-735-7245; Northern-635-7488/7432; Southern-828-7543.

Head of Household's Name _____ SSN/Case Number: _____

Which program(s) are you reporting for? ☐ SNAP (formerly Food Stamp) ☐ Cash Assistance ☐ Medical Assistance

HOUSEHOLD MEMBERS

Are you reporting a newborn in your household? ☐ YES ☐ NO
Did anyone or will anyone move in or out of your household? ☐ YES ☐ NO
If YES to any of the questions above, please complete the information below.

Household Member	Relationship to you	Social Security #	Birth date mm / dd / yy	Date moved IN	Date moved OUT	Marital Status	Sex	U.S. Citizen
			/ /	/ /	/ /			☐ YES ☐ NO
			/ /	/ /	/ /			☐ YES ☐ NO

Did any of the **NEW** household member(s) receive **SNAP, MEDICAL ASSISTANCE** or any other **CASH ASSISTANCE** from any state or U.S. Territory in the last month? ☐ YES ☐ NO
If YES, what type of assistance? _____ Where? _____ When? _____

INCOME

EARNED INCOME: Changes in gross earned income of everyone in your household must be reported. Attach pay stubs or a signed statement from employer of all income received for the month. **Cash and Medical Assistance households** must report all income. **SNAP (Food Stamp) households** are required to report changes of $100 or more in total gross monthly income or if the source of income changes.

Did you or anyone in your household start a job or is expecting to start a job? ☐ YES ☐ NO
Did you or anyone in your household stop working? ☐ YES ☐ NO
Did you or anyone in your household quit a job? ☐ YES ☐ NO
Did you or anyone in your household have a job that changed? ☐ YES ☐ NO
Did you or anyone in your household receive an increase or decrease in income from a job? ☐ YES ☐ NO
If YES to any of the questions above, please complete the information below and submit verification/documentation for any of the reported change(s) within ten (10) days.

NEW INCOME / INCOME THAT HAS STOPPED

Household Member	Employer or other source of income	Start Date mm/dd/yy	Stop Date mm/dd/yy	# Hrs Worked per Week	Wages per Hour	TIPS	Overtime (OT)	How Often Paid? (Use Codes Below)
		/ /	/ /					
		/ /	/ /					

PAY CODES: Weekly – **WK** Bi-weekly – **2X** Semi-Monthly – **SM** Monthly - **MN**

UNEARNED INCOME: CASH or MEDICAL HOUSEHOLDS must report all income**. SNAP (FOOD STAMP) HOUSEHOLDS** are required to report a change in monthly income of **$50 or more** and if the **source of income changes**. List the type and amount of unearned income received (such as **Social Security**, **Workman's Compensation**, **Child Support**, etc.) and attach documentation/ verification.

Type of Income	Who is receiving the income?	Date Started	Date Stopped	Monthly Amount
		/ /	/ /	$
		/ /	/ /	$

ASSETS: Please complete this section if you or any member of your household had a change in assets, including members who moved into your household.

Name of Household Member	Bank or Financial Institution	Type of account (Checking / Savings / Stocks / Bonds, etc.)	Is this an existing account?	Date account was OPENED	CLOSED	Amount / Balance

Have you or any member of your household bought, sold or traded any vehicle(s), boat(s), recreational vehicle(s)?
☐ Bought Value: $_____ ☐ Sold Value: $_____ ☐ Traded Make/Model: _____ Year: _____
Are there any other changes in assets (Properties, land, life insurance, etc.)? Please explain below.

_____
_____

EXPENSES

Have you or anyone in your household been billed for any child or adult care expense(s)? ☐ YES ☐ NO
Who was receiving the child/adult care? _____
If YES, provide verification/documentation (example; receipt / contract).
Did you or any member of your household make any court ordered child support payments? ☐ YES ☐ NO
If YES, provide verification/documentation to include date paid, amount, and who it was paid to.

Have you moved or will you be moving? ☐ YES ☐ NO

If YES, provide verification/documentation of your new address and your portion of the rent or mortgage if applicable.
New Address: _____ _____ _____
(Street, Village, State, Zip Code) (Date moved or will move) Rent Amount

Mailing Address (If different than above address): _____
What utilities do you pay? Please check all boxes that apply and provide verification/documentation.
☐ Power ☐ Water ☐ Sewer ☐ Trash ☐ Cooking Fuel ☐ Telephone

HEALTH INSURANCE: For MEDICAL ASSISTANCE households

Have you or any member of your household terminated medical coverage? (Do not include MIP or Medicaid) ☐ YES ☐ NO
If YES, with what insurance? _____ Termination Date? _____
Do you or any member of your household have medical coverage available or any changes to your medical coverage? ☐ YES ☐ NO
If YES, please complete the information below.

Name of household member	Name of Insurance	Effective Date

Are you or your spouse paying for this insurance? ☐ YES ☐ NO
If YES, how much is paid for this insurance? $_____

OTHER INFORMATION

Is there any other change you would like to report to your Eligibility Specialist? ☐ YES ☐ NO
If YES, explain below. (If more space is needed, attach a separate sheet)

_____
_____
_____

PENALTY WARNING

Failure to report such changes may result in an under-issuance of SNAP (Food Stamp) and/or Cash benefits for which you will not be reimbursed or an over-issuance of SNAP and/or Cash benefits that you must pay back or your case may be closed due to Intentional Program Violation (IPV). If you are found guilty of IPV under the SNAP and/or Cash programs, you will be disqualified for one (1) year for the first violation, two (2) years for the second violation, and permanently for the third violation. You may also be criminally prosecuted and fined up to $10,000 and/or imprisoned up to five (5) years. For the Medically Indigent Program (MIP), if you fail to report information that would have made you ineligible, you will be disqualified for three (3) months for the first violation; six (6) months for the second and subsequent violations.

Person Reporting Change: ☐ **Household Member** ☐ **Other** ☐ **Authorized Representative**

_____/_____
Print Name **Signature** **Date** **Contact Number(s) /** **E-Mail Address**