



## Change of Circumstances

Read all sections carefully. **Check all boxes that apply to your household.** Sign, date, and return this form to your local office. If you have any questions, or if you need a postage paid envelope to return this form by mail, contact your local office.

YOUR NAME	SOCIAL SECURITY NUMBER
YOUR CASE NUMBER (CLIENT ID NUMBER)	DATE
<b>FOR OFFICE USE ONLY</b> <b>CHANGE REPORTED BY TELEPHONE ON (LIST DATE)</b>	
<b>WORKER'S NAME</b>	

**Your Responsibilities:** If your household gets cash assistance, medical assistance, or Basic Food, you must report changes as described under WAC 388-418-0005 based on the benefits you receive. You must tell us about these changes by the 10th day of the month after the date the change happened. If you tell us about a change that you do not have to tell us about, we must look at how this impacts your benefits. This could cause you to receive fewer benefits, or have your benefits end. For Basic Food, if you voluntarily report a move to a new residence, you must also report your new shelter costs in section 2, even if you have not been billed for them yet. If you do not give us your new shelter costs we will use \$0. This could cause you to receive fewer benefits.

### 1. My address changed.

I moved. Date of move: \_\_\_\_\_  My mailing address changed.  I am homeless.

My new living address is:	My new mailing address (if different) is:
APARTMENT NUMBER (IF ANY)	APARTMENT NUMBER (IF ANY)
CITY STATE ZIP CODE	CITY STATE ZIP CODE

### 2. My shelter costs changed.

For Basic Food, report **only if** you have an increase or you move to a new residence. Report any other changes in shelter costs at **your next mid-certification or eligibility review**. Check all that apply.

<input type="checkbox"/> I am renting.	<input type="checkbox"/> I am buying.	<input type="checkbox"/> I am on subsidized housing.
MONTHLY RENT AMOUNT \$	YOUR SHARE, IF DIFFERENT \$	MONTHLY MORTGAGE AMOUNT \$
		MONTHLY PAYMENT AMOUNT (LIST YOUR SHARE ONLY) \$

I pay separately for (check all that apply):

<input type="checkbox"/> Heating/cooling costs I pay: \$ _____ per month.	<input type="checkbox"/> Telephone I pay: \$ _____ per month.	<input type="checkbox"/> Home insurance I pay: \$ _____ per month.	<input type="checkbox"/> Property taxes I pay: \$ _____ per month.
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### 3. Some moved in or out of my home. Check all that apply and indicate the date of the move.

#### Someone moved **INTO** my home.

Date: \_\_\_\_\_

List all who moved in (including newborns):

NAME(S)	RELATIONSHIP TO ME

I purchase and prepare meals with my roommates (check box that applies):  Yes  No

I want to include someone in my:

Cash  Basic Food  Medical assistance  
 Child care

If so, who? List names.

#### Someone moved **OUT OF** my home.

Date: \_\_\_\_\_

List all who moved out:

NAME(S)	RELATIONSHIP TO ME

I expect the person(s) will move back in with me (check box that applies):  Yes  No

If so, who? List names:

When do you expect the person(s) to move back in?

**4.  My household's income has changed. Examples of income include earnings or wages from a job or self-employment, unemployment benefits, Social Security, SSI, Labor and Industries (L&I), child support, veterans benefits (VA), gifts, or loans. Check all that apply.**

- Income or Job STARTED.** Date income started: \_\_\_\_\_ Who's income started: \_\_\_\_\_  
 Gross amount (dollar amount before taxes): \$ \_\_\_\_\_ per  hour  month  
 Income type: \_\_\_\_\_ Name of employer (if any): \_\_\_\_\_  
 Full-time  Part-time Date(s) person gets income (i.e., 1<sup>st</sup> and 15<sup>th</sup> of each month or every Friday): \_\_\_\_\_
- Income or Job ENDED.** Date income stopped: \_\_\_\_\_ Who's income stopped: \_\_\_\_\_  
 Reason why income stopped: \_\_\_\_\_
- Income or Job INCREASED.** Date income increased: \_\_\_\_\_ Who's income started: \_\_\_\_\_  
 Gross amount (dollar amount before taxes): \$ \_\_\_\_\_ per  hour  month  
 Income type: \_\_\_\_\_ taxes): \$ \_\_\_\_\_ Name of employer (if any): \_\_\_\_\_  
 If working, is this a change from **part-time** to **full-time**?  Yes  No
- Income or Job DECREASED.** Date decreased started: \_\_\_\_\_ Who's income started: \_\_\_\_\_  
 Gross amount (dollar amount before taxes): \$ \_\_\_\_\_ per  hour  month  
 Income type: \_\_\_\_\_ Name of employer (if any): \_\_\_\_\_  
 If working, is this a change from **part-time** to **full-time**?  Yes  No

**5.  My household's resources changed. I or someone in my household got (check all that apply):**

- A bank account (check all that apply):  Checking  Savings  CD's  Money Market  
 Amount in account: \$ \_\_\_\_\_ Date account opened: \_\_\_\_\_
- A vehicle: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Date received: \_\_\_\_\_
- An income tax refund: \$ \_\_\_\_\_ How much was Earned Income Tax Credit (EITC)?: \_\_\_\_\_  
 Date received: \_\_\_\_\_
- A lump sum payment (includes retroactive benefits, settlements, or an inheritance): \_\_\_\_\_  
 Date received: \_\_\_\_\_
- Other resources (list): \_\_\_\_\_

**6.  My household has other changes. Check all that apply.**

- I need child care assistance.
- My child care (babysitting) costs changed from: \$ \_\_\_\_\_ /month to \$ \_\_\_\_\_ /month.
- Pregnancy started for: \_\_\_\_\_; Expected due date: \_\_\_\_\_.
- Pregnancy ended for: \_\_\_\_\_; Date pregnancy ended: \_\_\_\_\_.
- Child support payments changed from: \$ \_\_\_\_\_ /month to \$ \_\_\_\_\_ /month.  
 Who pays child support: \_\_\_\_\_
- Medical expenses increased from: \$ \_\_\_\_\_ /month to \$ \_\_\_\_\_ /month.  
 Who pays the expense: \_\_\_\_\_
- Marital status changed for: \_\_\_\_\_  Married  Divorced  Separated  Widowed
- Private medical coverage ended for: \_\_\_\_\_; Date coverage ended: \_\_\_\_\_  
 Insurance company name and phone number: \_\_\_\_\_
- Private medical coverage began for: \_\_\_\_\_; Date coverage began: \_\_\_\_\_  
 Insurance company name and phone number: \_\_\_\_\_

OTHER CHANGES (DESCRIBE)

**7.  I want to terminate my:  Cash assistance  Basic Food  Medical assistance  Child care**

**Declaration and Signature**

I state under penalties of perjury that the information I give is true and complete to the best of my knowledge. I understand that if I give false, misleading, or incomplete information, I may be penalized under law (RCW 74.08.055 and RCW 74.08.331). I understand that the information I give is subject to verification and agree to provide the verification. If I can't provide the needed proof, I authorize DSHS to contact other persons or agencies to get the proof on my behalf. My signature on this form means that I have reported all changes that I must report.

SIGNATURE	DATE	TELEPHONE NUMBER
SIGNATURE OTHER ADULT HOUSEHOLD MEMBER OR REPRESENTATIVE	DATE	TELEPHONE NUMBER