DSHS WASHINGTON STATE Department of Social and Health Services

Change of Circumstances

YOUR NAME	CLIENT ID OR SOCIAL SECURITY NUMBER

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 Responsibilities: If your household gets cash, Basic Food, or medical assistance, you must report changes as described under WAC 388-418-0005, 182-504-0105 and 182-504-0110 based on the benefits you receive. For cash and food assistance programs, you must tell us about these changes by the 10th day of the month after the date the change happened. For medical assistance, you must tell us within 30 days of when 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 may result in fewer benefits, or your benefits may 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:

APARTMENT NUMBER (IF ANY)

CITY STATE ZIP CODE

My new mailing address (if different) is:

APARTMENT NUMBER (IF ANY)

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.

☐ I am renting. ☐ I am buying. ☐ 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):

☐ Heating / cooling costs I pay: $_____ per month.

☐ Telephone I pay: $_____ per month.

☐ Home insurance I pay: $_____ per month.

☐ Property taxes I pay: $_____ per month.

3. ☐ Someone moved in or out of my home. Check all that apply and indicate the date of move.

☐ Someone moved INTO my home. Date: _____

List all who moved in (including newborns):

NAME(S)	SEX	RELATIONSHIP TO ME	SOCIAL SECURITY NUMBER

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

I want to include someone in my: ☐ Cash ☐ Basic Food ☐ Child care ☐ Medical Assistance

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

I want to include someone in my: ☐ Cash ☐ Basic Food ☐ Child care ☐ Medical Assistance

If so, who? List names:

4. ☐ 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: _____

☐ A tax refund: $_____ Date received: _____
How much was Earned Income Tax Credit (EITC): $_____

☐ A lump sum (includes retroactive benefits, settlements, or an inheritance): _____

☐ Other resources (list): Date received: _____

5. ☐ 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 (before taxes): $_____ per ☐ hour ☐ month ☐ Full-time ☐ Part-time
Income type: _____ Name of employer (if any): _____
Date(s) person gets income (i.e., 1st and 15th 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: _____ 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): _____

6. ☐ My household has other changes. Check all that apply. Unverified changes in deductions that might cause an increase in benefits will not be updated until your next review unless we receive verifications of the change.

☐ My childcare (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: _____
☐ Medical expenses increased from: $_____ / month to $_____ / month.
Who pays: _____
☐ Marital status changed for: _____ ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Private medical coverage ended for: _____; Date coverage ended: _____
☐ Private medical coverage began for: _____; Date coverage began: _____
List insurance company name and phone number if coverage ended or began:
☐ I received a Low Income Home Energy Assistance Act (LIHEAA) payment in the past 12 months.
Amount: _____
☐ Lottery or gambling winnings of $4,750 or more (dollar amount before taxes): $_____;
Who: _____; Date received: _____

OTHER CHANGES (DESCRIBE)

Food Assistance Penalty Warning

We check with other agencies that your information is correct. If any information is incorrect, the persons who apply may not get Food Assistance.
Any member who breaks any of the rules on purpose can be:

- **Subject to prosecution under other applicable Federal and State laws**
- **Disqualified from SNAP for one year up to permanently**
- **Fined up to $250,000**
- **Imprisoned up to 20 years; or**
- **Disqualified from SNAP for an additional 18 months if court ordered.**

If a court finds you guilty of:

Receiving benefits in a transaction involving:	**You may be:**
• **The sale of a controlled substance.....**	**Disqualified from two years to permanently.**
• **The sale of firearms, ammunition, or explosives .....**	**Permanently disqualified.**
• **Trafficking benefits of more than $500 combined.....**	**Permanently disqualified.**
• **Residency or identity fraud .....**	**Disqualified for 10 years**

Voter Registration

The Department offers voter registration services as required by the National Voter Registration Act of 1993. **Applying to register or declining to register to vote will not affect the services or amount of benefits that you may be provided by this agency.** If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Washington State Elections Office PO Box 40229, Olympia, WA 98504-0229 (1-800-448-4881).

Do you want to register to vote or update your voter registration? ☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time.

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