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05/2019

AGENCY CHANGE REPORT FORM

CASE NAME: _____SSN: _____ DOB: _____

PHONE: _____REPORTED BY:_____DATE: _____

CHANGE IN ADDRESS

Date Moved:

Current Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City_____ State: _____ Zip: _____

Does the client need a new EBT card issued?

CHANGE IN HOUSEHOLD COMPOSITION

Other HH Members:	Relationship:	SSN:	DOB:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHANGE IN DEDUCTIONS

Amount $ _____ Frequency: _____

Landlord/Bank Name: _____ Telephone #: _____

Collateral Name: _____ Telephone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Utility Expenses: _____ Heating Source: _____ Air Conditioner: _____

Are you paying Child Care? _____ If Yes, How Much? $_____ Frequency? _____

To Whom? _____ Phone #: _____

Address: _____ Does DSS Assist? _____

Notes:

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CHANGE IN INCOME

Earned Income:

Member Working: _____ Name of Employer: _____

Address: _____ Phone #: _____

Hours per Week: _____Rate of Pay: _____ Day Pay Received: _____ Freq: _____

Date Employment : _____ Date of Pay: _____

Applied for UIB? _____

Unearned Income:

Member Receiving? _____Type of Income: _____

Amount:$ _____ Frequency: _____ Date : _____

Notes:

CHANGE IN HOUSEHOLD/ BUDGET UNIT COMPOSITION

(includes newborns, death & hospitalization)

Person Moving Out:

Member: _____ Relationship: _____

Where did they move to: _____ Date Moved Out: _____

Person Moving in:

Date Moved in: _____

Member: _____ DOB: _____

SSN: _____ Relationship: _____

Is this person receiving FNS or Medicaid in another State/County? _____

Do they have income? Resources? Type? _____ Amount: _____

Employer: _____ Phone #: _____

Address: _____

hours per Week: Rate of Pay:$ _____ Frequency: _____Day Received: _____

AP's Name (if child): _____ Phone#:(if known) _____

Carolina Access Provider: _____ Private Insurance: _____

Child Age 16-21 (dropped out of school)

Name of Child: _____ Date School Stopped: _____

Employer: _____ Phone #: _____

Address: _____

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Change in Reserve:

Type: _____ Amount: _____ Date of Change: _____

FCMED CHANGES ONLY

Reporting Pregnancy if yes, continue. If no, skip to next section.

a. Name of Pregnant Member: _____
b. Pregnancy Due Date: _____if due date is unknown, date of last menstrual cycle: _____

TAX FILING QUESTIONS

Do you plan to file a federal income tax return NEXT YEAR? If yes, continue. If no, skip to question c.

a. Will you file jointly with a spouse? If yes, name of spouse: _____
b. Will you claim any dependents on your tax return? _____

If yes, list name(s) of dependents:

Name	Income	if yes, what kind?	Will they be filing their own tax return?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

c. Will you be claimed as a dependent on someone else's tax return?

If yes, please list the following:

1. Name of the tax filer: _____
2. Relationship to tax filer: _____
3. Tax filers income: _____
4. Do they have any other dependents: _____

ADDITIONAL NOTES: