DPHHS-HCS-260A
(REV 03/16)

State of Montana
Department of Public Health and Human Services
Human & Community Services Division

TANF/Medicaid Change Report Form

Name:	**Phone Number:**
Case Number:	**Message Phone Number:**

INSTRUCTIONS: For TANF and Medicaid you must report changes within 10 days of knowing of the change. You might be asked to provide verification. Use a separate sheet if you need more room.

CHANGE IN ADDRESS

I am moving to _____
Street Address *City* *State* *Zip* *County*

My **mailing** address will be _____

My old address was on an Indian Reservation: ☐ **Yes** ☐ **No**
My new address is on an Indian Reservation: ☐ **Yes** ☐ **No**

CHANGE IN HOUSEHOLD MEMBERS

Total number of people **now** in my home: _____

Reminder: If an adult is being added to your home, an "Adding a New Member" (HCS-261A) form is required. If an individual has left your home, a "Household Member Absence" (HCS-262) form is required for TANF. Please ask for the form(s).

Date of Change (mm/dd/yy)	Name	Moved		Has Income		Has Resources		Relationship to Person Listed Above
		In	Out	Yes	No	Yes	No	

CHANGE IN DEPENDENT CARE

This section is only for those who are receiving TANF or family-related Medicaid and not for those who are only receiving Medicaid due to being aged (65 or older), blind or disabled.

Does your household pay childcare or adult dependent care so a household member can work, look for work or attend training? ☐ **Yes** ☐ **No**

If yes, attach a signed statement from your care provider that lists: a) each person cared for, b) dates of care, c) hours of care, d) your monthly cost.

Does someone else (such as a roommate, relative or other agency) pay any of your dependent care costs? ☐ **Yes** ☐ **No**

If yes, please explain: _____

CHANGE IN RESOURCES

Has anyone in the household received money, opened or closed bank accounts, obtained life insurance, property or other valuable items or have total combined resources with a current value of $2000 or more? ☐ **Yes** ☐ **No**

If yes, please explain: _____

CHANGE IN VEHICLES ***(car, van, motorcycle, off-road vehicle, boat, etc)***

Bought _____ Sold_____ Traded_____ Gave away vehicles_____

Year _____ Make _____ Model _____

Value $_____ Amount owed (if any) $_____

CHANGE IN INCOME

New Employment Name of the person with new employment _____

Date Job Started ___/___/___ Name of Employer/Business_____

Are you Paid: Weekly ___ Every Other Week ___ Twice a Month ___ Monthly ___ Other ____

First Pay date ___/___/___ Hourly Wage **$**_____ Number of shifts per week_____

Number of hours per shift_____ If tips are received, estimate the monthly amount $_____

Is health insurance offered through this employer, either now or at a later date? ☐ **Yes** ☐ **No**

Current Employment Name of the person with employment change _____

Date of Change ___/___/___ Name of Employer/Business _____

Date Job Started ___/___/___ Number of shifts per week_____ Number of hours per shift_____

Hourly Wage $_____ ☐ Increased ☐ Decreased

Employment Ended Name of the person whose job ended _____

Name of Employer/Business _____ Last Day of Work ___/___/___

Reason Job Ended: ☐ Laid Off ☐ Quit ☐ Fired ☐ Other _____

Date Last Check Received ___/___/___ Gross Amount of Last Check **$**_____

Unearned Income *(example: child support, unemployment, workers' compensation, pension, interest income, Social Security, etc)*

Person with unearned income: _____ How often received: _____

Date ___/___/___ ☐ Unearned Income Started ☐ Unearned Income Stopped

Current Amount $_____ ☐ New ☐ Increased ☐ Decreased

OTHER CHANGES

☐ School attendance Who? _____ Date began ___/___/___ Date ended ___/___/___

☐ Pregnancy Who? _____ Expected due date ___/___/___

☐ Health Insurance _____ Medical Costs_____

☐ Martial Status _____

☐ Child support (Legal obligation to pay to someone not living with you in your household.)

_____

☐ Other: _____

REMINDER: You may need to give proof of reported changes. If any of the changes you reported today change in the future, please be sure to report them as new changes.

My answers on this form are correct and complete to the best of my knowledge**. I understand that the information I provide on this report may reduce or stop my benefits and I may receive notice less than 10 days before the change.**

Signature:	**Date:**