



Change Report

You must report changes if you receive benefits from the Economic Services Division. If you are not sure what you must report, call the Benefits Service Center at 1-800-479-6151.

If something changes, fill out this form and return it with needed proof in the enclosed postage-paid envelope. **Please do not send originals since we cannot guarantee they will be returned to you.** If you need more space, attach a separate sheet. A worker will process the change and you will get a notice if your benefits change.

Please print:

Name _____ Social Security no. xxx-xx-_____
(Last four digits only)

Phone number _____

Please check the programs you are currently on: 3SquaresVT Reach Up Medicaid/Dr. Dynasaur
 VHAP/Premium Assistance/Pharmacy Essential Person Home Heating Assistance

Please check the appropriate boxes and fill in only the things that have changed. Do not fill in sections where there are no changes.

Address and Housing Change (Send proof such as bills, receipts, or signed statements.)

My new mailing address is _____

My physical address is _____

I moved to a: one-family house mobile home apartment house other _____

Number of bedrooms _____ Number of people in home _____

My housing expenses changed. My new cost is:

rent or lot rent \$ _____ per _____ My rent is based on my income Section 8 public housing
 subsidized housing other

room \$ _____ per _____ Meals included? Yes No

mortgage \$ _____ per _____ taxes \$ _____ per _____

homeowner's insurance \$ _____ per _____

I now share expenses with _____ Which expenses? _____

My share of expenses is: half a third a quarter other _____

Must check one:

I pay to heat my home. Fuel supplier's name and address _____ Phone number _____

Name on account _____ Account number _____

Heat is included in my rent.

My landlord bills me for heat.

Must check one:

The MAIN type of fuel used for HEAT is: oil propane kerosene natural gas coal firewood/pellets electric

Income Change (Send proof such as paystubs, notice or letter from employer.)

Someone in my household has a new job. This is an *additional* job.
Name _____ Date of first pay _____ Date job started _____

Gross pay \$ _____ per _____ Employer _____

Someone gets a higher or lower rate of pay. Date of change _____
Name _____ New gross pay \$ _____ per _____

Someone left a job. Effective Date _____
Name _____ Date of last pay _____ Gross Amount \$ _____

Someone changed scheduled hours of work per week. Date of change _____
Name _____ Old hours _____ New hours _____

Someone gets a different amount of unearned income: SSI/AABD unemployment social security child support

other _____ Old amount \$ _____ New amount \$ _____ Date _____

Expense Change *(Send proof such as bills, receipts, or statements.)*

- Child care costs changed to \$ _____ per _____ for (name) _____
- Adult dependent care costs changed to \$ _____ per _____
- Paid child support changed to \$ _____ per _____

Household Member Change

- (Name) _____ moved out on (date) _____
 - (Name) _____ moved in on (date) _____
 - (Name) _____ and (name) _____ were married on (date) _____
 - (Name) _____ had a baby on (date) _____
- A worker will contact you for more information about the new person in your household.*

Resource Change *(Send proof.)*

- Savings increased to \$ _____ Explain _____
Bank/Credit Union/other _____ Account Number _____
- Other accounts increased to \$ _____ Explain _____
Bank/Credit Union/other _____ Account Number _____
- Bought/inherited real estate \$ _____ Amount of equity \$ _____
- Sold real estate for Amount sold for \$ _____ Amount of equity \$ _____
- Bought, inherited, or was given a vehicle Make _____ Model _____ Year _____
Amount owed \$ _____ Fair market value \$ _____
(such as car, truck, motorcycle, snowmobile, RV, or ATV)
- Sold or traded a vehicle Make _____ Model _____ Year _____
Amount owed \$ _____ Fair market value \$ _____
(such as car, truck, motorcycle, snowmobile, RV, or ATV)

Health or Life Insurance Change

New Insurance

Persons covered _____ Policy number _____ Group number _____ Start date _____

Name and address of insurance company _____

- Type of coverage (check all that apply): Doctor Dental Major medical Outpatient Hospital Prescriptions
 Other-type: _____

Insurance Ending

Date coverage ended _____ Persons no longer covered _____

Name of company _____

Reason insurance ended: Lost a job Death of employee carrying insurance Divorce

No longer eligible as a dependent under a policy held by the individual's parents Other _____

Other Changes *(Use this space or another sheet of paper to report any other changes.)*

Please sign and date this form here.

Signature _____	Date _____
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If you have questions, please call the Benefits Service Center at 1-800-479-6151.
Statewide relay service for the hearing impaired 1-800-253-0191 (TDD) or 1-800-253-0195 (voice)