Georgia Department of Human Services
Division of Family and Children
Services Change Report Form

Please use this form to report changes in your household circumstances to the Department of Family and Children Services. **If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).**

DO NOT RETURN THIS FORM UNLESS YOU ARE REPORTING A CHANGE IN CIRCUMSTANCES.

Name:_____ Client ID# _____

Address:_____ Case# _____

_____ Worker Phone#_____

Simplified Reporting Households must report:

When their total monthly gross income is more than 130% of the income level for their household size.

When an Able-Bodied Adult without Dependents (ABAWD) work hours fall below 20 hours per week or 80 hours per month. **These**

When you or a household member receives substantial lottery or gambling winnings. This is a cash prize won in a single game. If y

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Although your household only has simplified reporting requirements, you may report any of the following changes:

Check the changes that you are reporting and complete the questions on this form.

Change in who lives in the household because someone moved in or out Household moved to a new address
Household member(s) started to work Household member(s) stopped working
Household member(s) has a change in hourly pay rate or hours
Household member(s) started to receive or stopped receiving SSI, social security, VA, pension, retirement, disability, money from fr
Someone had a change in household expenses and bills
You or someone in your household has resources of $2750 or more. If elderly or disabled, resources of $4250 or more.

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H O U S E H O L DC O M P O S I T I O N

- Who moved in?Who moved out? When did the person move in or out?
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A D D R E S S

- My household has moved to a new address. The new address is

  _____

  _____

- New Rent or Mortgage Amount $ If a mortgage, the annual property tax is $ and the amount for homeowner's insurance is $.
- Does anyone help you pay your rent, mortgage or utilities? Yes If yes, who?
  No

  _____

- At your new address, what utilities do you pay?
- Do you have to pay for heating or air conditioning? Yes_ No

I N C O M E

- Who had a change in income or employment?
- Where does the income or employment come from?

  _____

- How often is the income received? When did the income or employment start?
  What is the new amount of income? When did the income or employment stop?
- What is the last payment amount received?
-
-
-

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M E D I C A L E X P E N S E S				
Does anyone age 60 or older or disabled have medical expenses? Yes _____No_____ If yes, complete chart below.				
Household Member Billed	Type of Expense (Doctor, Hospital, Prescriptions, Medicare premium)	Amount Owed	Date of Bill	Will Insurance Pay? (Yes/No)

C H I L DS U P P O R TP A Y M E N T

Do you or someone in your household pay child support to someone living outside of the home?

No Yes

Who is obligated to pay? How much is the obligated amount?
For whom is the child support paid? To whom is the child support paid? How often is the child support paid? How much is the actual amount

D E P E N D E N T C A R E E X P E N S E S			
Person who requires care:	Person who pays for care:		
Provider's Name:		How much provider is paid:	How often paid:
Provider's Phone #:	Reason for Care:		

Form 846 (Rev

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R E S O U R C E S			
Does any person in your household have the following resources? Yes_____No If yes, complete chart below.			
Resource Type	**Owner**	**Amount/Value**	**Bank Name**
Cash			
Checking/Savings			
Credit Union			
Stocks or Bonds			
Safe Deposit Box			

My household had **total monthly gross income** (earned - before deductions AND unearned income) that is more than 130% of the income limit.

In what month/year did the household's income exceed the 130% amount?_____/
Month Year

What is the total monthly gross income amount?

Signature_____Date

My household had an **ABAWD member whose work hours fell below 20 hours per week**.
I,_____, am an unemployed ABAWD who was working 20-29 hours per week or 80 hours per month. My work hours have decreased to_____hours per week.

Signature_____Date

My household had a household member who received **lottery or gambling winnings**.

In what month/year did the household member receive lottery/gambling income?_____/
Month Year

What is the total gross lottery/gambling income amount?

Signature_____Date

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I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to Food Stamp/Medicaid and/or TANF program requirements. I will also report If anyone in my household receives lottery or gambling winnings, gross amount of $4250 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses at my application or renewal interview and/or fail to verify them that DHS-DFCS will not budget that expense in calculating the amount of my food stamp benefits.

Signature_____ Date_____

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____Yes

_____No

_____I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application 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 the Secretary of State at: 2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

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Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at 404-657-3433 or the DCH Katie Beckett (KB) Team at 678-248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form at the KB Team or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, Ste. 19-454, Atlanta, GA 30303, 404-657-3735. For DCH, contact the KB Team ADA/Section 504 Coordinator at: 2211 Beaver Ruin Road, Suite 150, Norcross, GA 30071 or P.O. Box 172, Norcross, GA. 30091, 678-248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at: https://dch.georgia.gov/adasection-504-and-civil-rights.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) is within the "Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

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Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights and ADA/Section 504 Coordinator at 2 Peachtree Street NW, Ste. 19-454, Atlanta, GA 30303, 404-657-3735. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, Ste. 19-454, Atlanta, GA 30303 or call 404-657-5244 (voice).