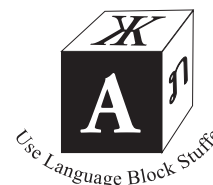


Household Report Form

Case number: _____

How to fill out this form:

1. Your REPORT MONTH(S) is _____
2. Fill out and return this form or your benefits may be late or stop.
3. Answer Yes or No to each question.
4. If there is not enough room on the form to answer a question, attach your own pages.
5. Sign and date the form *on or after* _____
6. Return this form *no later than* _____
7. If you need help with the form, call _____



This information is available in other forms to people with disabilities by calling your county worker. For TTY/TDD users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Important - Read this

- **Your right to file a complaint:** If you feel the county or Minnesota Department of Human Services treated you differently in the handling of a public assistance application or payment because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability (including access to buildings or programs), you may file a complaint.
- **How we use this information:** Our public assistance staff and other agencies allowed by law use the information on this form. We also use it to refer you to other benefit programs. If you move to another state or county, we will send certain information to them.
- **Your right to a fair hearing:** You have the right to a fair hearing if you do not agree with an action taken by the county agency. Request a fair hearing by calling or writing your county human services agency or the Minnesota Department of Human Services, State Appeals Office, PO Box 64941, St. Paul, MN 55164-0941.
- **Denial and notice actions:** We may deny or change your cash or health care and/or food support benefits because of information you give on this form. We can make changes **without giving you 10 days advance notice**. We will send you written notice of any change no later than the date the change takes effect or the date you would receive benefits, whichever is earlier.
- **False information:** If you give false information, we may try you for fraud and you could lose your benefits.

1. Address change: Did you move during the report month(s)?

 Yes No

 If yes, date of last move:

NEW STREET ADDRESS	CITY	STATE	ZIP CODE	NEW PHONE NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Household members: Did anyone move out of your home in the report month(s)?

 Yes No

Did anyone move in with you in the report month(s) (include newborns)?

 Yes No

Have you either moved on to a reservation or left a reservation in the last month?

 Yes No

If yes for any question in #2, fill in the boxes below for each person who moved in or out:

Name	Relation to you or your children	Date of change	Was change for 30 days or less?	Does person buy or fix food with you?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Assets: Did you or anyone living with you have *any* assets during the report month(s)? List *all* assets.

Check Yes or No for each item. If yes, list the cash value and the owner. Send proof of changes.

		Value	Owner's name
• Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Savings accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Checking accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Life insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Stocks/bonds or other securities	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Motor vehicles (list make and year below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. \$	
1. _____ 2. _____		2. \$	
• Burial funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
• Other such as IRAs, savings certificates, boats, campers, trailers, sponsor's assets.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. \$	
(Type) 1. _____	2. _____	2. \$	
	3. _____	3. \$	

4. Unearned income: Did you or anyone living with you receive *any* unearned income during the report month(s)?

 Check Yes or No for each item. If yes, list who got the money, how much they got *each* month, and date they got it.

Send proofs of any changes in unearned income.

		Amount	Who got it	Date received
• School loans, grants, scholarships	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• RSDI (Social Security)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• SSI (Supplemental Security Income)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• VA (Veteran's Benefits)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• Unemployment insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• Workers' Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• Retirement benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• Child or spousal support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
• Other such as tax refunds, gifts or loans, contract for deed income, rental income, lottery winnings, lawsuit settlements, inheritance.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. \$		
(Type) 1. _____	2. _____	2. \$		
	3. _____	3. \$		
	4. _____	4. \$		

 Go to next page 

5. Earned income: Were you or anyone living with you getting income from a job or self-employment during the report month(s)?

Yes No

If yes, complete the sections below for that person(s) for the Report Month(s).

HOUSEHOLD MEMBER		OCCUPATION		
EMPLOYER	STREET ADDRESS		CITY	

- How many hours did you work **in the report month**? _____
- **Send pay stubs or other proof of gross earnings and deductions (such as taxes and FICA).** If you don't have proof, have your employer sign where indicated.
- How often paid: Every week Every 2 weeks Once a month Twice a month Other

	1st check	2nd check	3rd check	4th check	5th check
Date pay received					
Gross earnings	\$	\$	\$	\$	\$
Tax deductions	\$	\$	\$	\$	\$
Tips/bonuses	\$	\$	\$	\$	\$
No. of hours worked					
No. of days worked					
No. of days with meal break					
EMPLOYER SIGNATURE (NEEDED IF YOU DON'T HAVE PAY STUBS)				DATE	

If self-employed, list business income and expenses on a Self-employment Report Form (DHS-3336).

- **Send proof of all self-employment income and business expenses.**
- **In-home day care:** If you get cash assistance or family medical and wish to claim the 60% flat rate instead of itemizing expenses, check here. (Ask your financial worker to explain both methods.)

How does this household member get to work?

- Drive (miles one way) _____ Special transportation arrangements (list _____)
- Bus (cost each way) \$ _____ Other (list _____)

Other work expenses (include any special equipment or special needs): _____

Does your household have more than one job to report?

If yes, attach a separate sheet with the above information about that job.

Yes No

6. Child or adult care: Did you or anyone living with you have costs for care of a child or an ill or disabled adult during the report month(s) because you or they were working, looking for work or going to school?

Yes No

If yes, complete the section below for each person getting care.

If there is a change in the person giving care, send proof of the new cost.

Name of person getting care	1.	2.	3.	4.
Name of person paying care				
Amount <i>you</i> paid in report month(s)	\$	\$	\$	\$
Amount paid <i>by someone else</i> in report month(s)	\$	\$	\$	\$
Name of person giving care				

7. Court-ordered expenses: Did anyone living in your household pay court-ordered expenses in the report month(s) (child/spousal support, medical, child care)?

If yes, send proof.

Yes No

PAID TO WHOM	AMOUNT PAID	TYPE OF PAYMENT

8. Shelter costs: During the report month(s), was there a change in your shelter costs?
 If yes, list your new costs. **Send proof of new rent, mortgage, taxes and/or insurance.**

Yes No

Costs

Costs

- Rent \$ _____ (per month)
- Mortgage \$ _____ (per month)

- Taxes \$ _____ (per month)
- Home insurance \$ _____ (per month)

Do you live in **subsidized** housing?

Yes No

Do you share housing costs with anyone? Who? _____

Yes No

9. Utility costs: During the report month(s) was there a change in the utilities you pay?
 If yes, check which utilities you now pay:

Yes No

- Heat and/or air conditioning
- Electric
- None
- Phone
- Other (list) _____

Does someone help you pay your utility costs? _____

Do you get Low Income Home Energy Assistance Program (LIHEAP) funds?

Yes No

10. Health insurance:

Are you or anyone living with you covered by Medicare, health or dental insurance or a Health Maintenance Organization (other than Medical Assistance paid coverage or MinnesotaCare)? If yes, name of company _____

Yes No

Could you or anyone living with you get health or dental insurance or Health Maintenance Organization coverage through a spouse, parent or employer?

Yes No

11. Other changes:

Do you or anyone living with you have any other changes to report? (*Examples: Starting or stopping school, starting or stopping work, marriage, selling or giving away assets, court-ordered community service.*) **Send proof of changes in work or assets.**

Yes No

If yes, who? _____ Explain and give the date of the change below:

In the next two months, do you or anyone living with you expect any changes in what you reported on this form? (*Examples: Starting or stopping a job, number of hours worked per month, starting or stopping school, marriage, moving, getting income.*)

Yes No

If yes, who? _____ Explain and give the date of the change below:

Comments: _____

Sign and date this report *on or after* the last day of the report month(s)

I declare that I have examined this form and, to the best of my knowledge and belief, it is a true and correct statement of every material point.			
SIGN YOUR NAME HERE	DATE	PHONE NUMBER.	
PRINT YOUR NAME HERE		PRINT YOUR CASE NUMBER HERE	
HAVE THE SECOND ADULT SIGN HERE	DATE	PERSON WHO HELPED COMPLETE THE FORM SIGN HERE	DATE