



Minnesota Department of **Human Services**

Minnesota Health Care Programs

Change Report Form

Keep this form until you have a change to tell us about. You must:

- Tell us about a change within 10 days of when it happens.
- Fill out the section below that applies to the change or changes and give us proof of the change.
- Sign and date this form and return it to the above address.
- Include or write your name and case number on any information you give us.

Date: _____
 Client's Name: _____
 Case Number: _____
 Worker Name: _____
 Worker Phone Number: _____
 Fax Number: _____
 Agency Name: _____
 Agency Address: _____

<input type="checkbox"/> New address or phone number			DATE OF CHANGE
NAME OF PERSON		STREET ADDRESS	
CITY	STATE	ZIP CODE	PHONE NUMBER

<input type="checkbox"/> Do you want to add/change the person acting on your behalf?	
<input type="checkbox"/> YES – WE WILL SEND YOU A FORM TO FILL OUT	

<input type="checkbox"/> Job		<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED		DATE OF CHANGE
NAME OF PERSON		EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER STREET ADDRESS			DO THEY OFFER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYER CITY	EMPLOYER STATE	EMPLOYER ZIP CODE	GROSS AMOUNT YOU EXPECT TO MAKE EACH MONTH	

<input type="checkbox"/> Self-employment business		<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED		DATE OF CHANGE
NAME OF PERSON		BUSINESS NAME		MONTHLY NET AMOUNT YOU WILL MAKE
Do the net business assets of all businesses total \$200,000 or less? <input type="checkbox"/> YES <input type="checkbox"/> NO				

<input type="checkbox"/> Other income		<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED		DATE OF CHANGE
EXPLAIN				

<input type="checkbox"/> Day care	<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED	DATE OF CHANGE
NAME OF PERSON PAYING DAY CARE		AMOUNT PAID PER MONTH

<input type="checkbox"/> Child support payments	<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED	DATE OF CHANGE
NAME OF PERSON PAYING CHILD SUPPORT		AMOUNT PAID PER MONTH

<input type="checkbox"/> Medical expenses: List all expenses not paid by your health care coverage.						DATE OF CHANGE
NAME OF PERSON	DATE OF SERVICE	TYPE (CO-PAY, BILL, PREMIUM, MILEAGE)	PROVIDER	AMOUNT OR NUMBER OF MILES	INSURANCE PAYMENT	BALANCE DUE

<input type="checkbox"/> Asset changes	<input type="checkbox"/> NEW <input type="checkbox"/> NO LONGER HAVE IT <input type="checkbox"/> CHANGED	DATE OF CHANGE	
NAME OF OWNER	TYPE (BURIAL AGREEMENTS, BANK ACCOUNTS, CONTRACTS FOR DEED, STOCKS, BONDS, CASH VALUE OF LIFE INSURANCE, RETIREMENT ACCOUNTS, ANNUITIES, IRA'S TRUSTS, OTHER)	LOCATION OR DESCRIPTION	VALUE

<input type="checkbox"/> Other health insurance	<input type="checkbox"/> STARTED <input type="checkbox"/> STOPPED <input type="checkbox"/> CHANGED	DATE OF CHANGE	
INSURANCE COMPANY NAME	PERSONS COVERED	TYPE	POLICY NUMBER

<input type="checkbox"/> Other changes	DATE OF CHANGE
NAME OF PERSON	EXPLAIN THE TYPE OF CHANGE (MARRIAGE, DIVORCE, PREGNANCY, DISABILITY)

<input type="checkbox"/> Household members	<input type="checkbox"/> MOVED IN <input type="checkbox"/> MOVED OUT	DATE OF CHANGE	
NAME OF PERSON	DATE OF BIRTH	RELATIONSHIP TO YOU	APPLYING <input type="checkbox"/> YES <input type="checkbox"/> NO

SIGNATURE OF PERSON FILLING OUT THE FORM	DATE	PHONE NUMBER

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.