CHANGE REQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 378 (3-2023)

Clear Fields

To report a change, please complete the appropriate section.

* In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number is voluntary and is requested for identification purposes only. Failure to disclose this information will not affect participation in this program.

Name	Telephone Number	*Social Security Number
Program(s) ☐ SNAP ☐ Health Care Coverage ☐ Child Care Assistance ☐ TANF ☐ LIHEAP		

1. ADDRESS (complete this section if you had a change in address)

New Address	City	State	ZIP Code
New Mailing Address (if different)	City	State	ZIP Code
Effective Date			

2. A. INCOME (EARNED) (complete this section if there has been a change in your **earned** income)

Household Member	Employer	New, Ended, or Changed	Date of Change	Date of First/Last Pay Stub

Attach pay stubs or other income documents if you have had a change in earned income.

Additional Information for NEW Employment

Rate of Pay	Hours per Week	Are tips received? ☐ Yes ☐ No	Amount of Tips Anticipated
How Often Paid ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month ☐ Other (specify):			

Additional Information for ENDED Employment

Reason Employment Ended ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (specify):

B. INCOME (UNEARNED) (complete this section if there has been a change in your **unearned** income)

Household Member	Income Source (ex: Unemployment, Child Support, Social Security, etc.)	New, Ended, or Changed	Amount	How Often Received

Attach pay stubs or other income documents if you have had a change in unearned income.

3. HOUSEHOLD MEMBERS (complete this section if anyone has moved in or out of the household)

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Name	Relationship	Date Moved In	Date Moved Out	Date of Birth	* Social Security Number

4. ASSETS (complete this section if there has been a change in a household member's assets)

Household Member	Type of Asset	Open/Closed, Bought/Sold	Amount or Value	Description (Name of Bank or Vehicle-Make/Model/Year	Other-Explain (Property, Land, Life Insurance, etc.)

5. EXPENSES (complete this section if there has been a change in a household member's expenses, such as child/spousal support, child care, rent, medical costs, etc.)

Household Member	Type of Expense	New Amount	Date of Change

6. HEALTH INSURANCE (complete this section if there has been a change in a household member's health insurance coverage)

Household Member	Started or Ended	Effective Date	Health Insurance Provider (Company)

7. A. CHILD CARE ASSISTANCE (ACTIVITY) (complete this section if you had a change in your allowable activity)

Household Member	Activity	Started/Ended	Date

B. CHILD CARE ASSISTANCE (CHILD'S HOURS OF NEED) (complete this section if you need to change the hours of child care needs)

Name of Child	Date Hours Increased	Child Care Hours Required per Week

C. CHILD CARE ASSISTANCE (PROVIDER) (complete this section if your child care provider(s) have changed)

Name of Child Care Provider (daycare)	Date Started	Date Ended	For Which Child(ren)

** for additional family and/or household member information, attach additional pages

PENALTY WARNING/RELEASE OF INFORMATION

The changes you report may be verified by federal, state, and local officials or by computer matches. Knowingly providing incorrect information may result in the loss of benefits or criminal prosecution.

I understand the information I have provided may result in a change of my benefits, including a reduction in the amount of benefits, or the loss of benefits. I understand that such changes may be made to my benefits without timely notice. I certify under penalty of perjury, that the information I have provided is true and accurate to the best of my knowledge.

Signature	Date
Other Signature (Spouse, Legal Representative, Guardian, or Other Adult)	Date

***** When Competed by the Customer Support Center

I spoke with the above named individual and confirmed the requested changes. I read the penalty warning to the above named individual, they confirmed their understanding of the penalty statement and authorized the changes to their case file.

Client Case Number	
Customer Support Center Staff Member Signature	Date

Return this signed and dated form, along with any verifications to your local human service zone office

OR

Submit by mail to:
Department of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506

OR FAX: (701)-328-1006

OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005
Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones