

Verification Of Change In Situation

Date: _____

Casehead

Case ID

County Case #

Worker #

Use this form to record changes in situation between reviews or to record changes reported on the Work First Family Assistance Report.

Method of Report (check): Phone In person Mail Work First Family Assistance Report

Date Change Reported: _____

Change In Income

Changed income: \$ _____ Earned Unearned
Gross Amount Frequency

Received by: _____ Source: _____

Complete an automated budget in EIS. The Work First Family Assistance payment is:

Unchanged Revised from _____ to _____ Terminated Effective: _____

Change of Address Moved out of county

New Address: _____

_____ Phone: _____ Home Work Message

Transfer to MAF-C Effective: _____

Someone Moved Out

Name: _____ Date of move: _____

Reason for move: _____

Someone is temporarily out of the home Name: _____

Date the absence began: _____ Return Date: _____

Reason: _____

The family member remains qualified for Work First Family Assistance. Change the individual CASE STATUS code in EIS to "A". (Refer to Work First Manual Section 112 regarding Temporary Absence)

Someone Moved In Move In Date: _____

A Child Was Born Is the child subject to the family cap? Yes No

If no, reason: _____

Complete the following for individual(s) who moved into the home or for a newborn.

Name: _____ Date of Birth: _____ Place of Birth: _____

Sex: ____ Race: ____ EIS ID#: _____ SSN (if applying for assistance) _____

Marital Status: _____ Spouse's Name: _____

Mother's Name: _____ Father's Name: _____

Relationship to Case head: _____

This individual is included in Work First Family Assistance.

Revised Payment Amount: \$ _____ Effective: _____

This individual is not included in Work First Family Assistance. Reason: _____

_____ Payment amount: \$ _____

Time Limit Extension Requested Request Date: _____ Reason: _____

Time limit request: Denied Approved length _____ Date Action Taken: _____

Administrative Reopen Requested Reopen requested by 10th of month Request Date: _____

Approved effective: _____ Denied -- Reason: _____
(A manual notice is required.) (If denied, evaluate for ongoing Medicaid.)

Reopen requested after 10th of month -- Request Denied **(Further benefits require an application.)**

Other: _____

Other changes: _____

Result: _____

By signing this form, I am saying that:

- Everyone I am applying for is a United States citizen or a qualified immigrant.
- I have read and understand my rights and responsibilities, including my right to claim good cause for refusing to cooperate with Child Support.
- All the information I have given is correct.
- I understand that if I choose not to sign this form, Work First Family Assistance may be denied, reduced or terminated.

Case head Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

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