HALL COUNTY HOUSING AUTHORITY
308-385-5530 or Fax 308-385-5533
CHANGE REPORT FORM

Case Manager Name:_____ **Date:**_____

Head of Household_____ **SSN:** _____

Spouse: _____ **SSN:**_____

Street Address: _____ **City:**_____ **State:** _____ **Zip:** _____

Email Address:_____

Phone Number:_____ **Best time and day to call:**_____

Please Note: in order to make any changes to your income we must have this form completed with any and all changes in your income or eligible medical expenses. Failing to provide complete and accurate information constitutes fraud, which would result in termination of your housing assistance.

EMPLOYMENT

(__) JOB STOPPED	**(__) JOB STARTED**
Who quit/lost job?_____	Who started job?_____
Old Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
Employer Phone #: _____	Employer Phone #: _____
Date Quit/Lost Job: _____	Date Job Started:_____
	Is this job temporary? Yes or no
Additional Information _____	Wages**:** $_____ per hour/week/month/year
_____	If hourly, hours per week: _____
_____	Tips: $_____ per week/month/year
	You must bring in your next three paystubs.

Eligible Medical/Disability Expense

(__) I have a new eligible medical expense	**(__) I'm no longer paying a medical expense**
Expense is for _____	Expense is for _____
Company Name _____	Company Name _____
Company Address _____	Company Address _____
Policy # _____	End Date _____
Start Date _____	

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Other Income

I have had a change in the following:

(__) Alimony/Child Support Start Date:_____ Amount: $_____ per week/month/year

Person Paying Child Support: _____

(__) Social Security Benefits Start Date:_____ Amount: $_____ per week/month/year

(__) ADC Start Date:_____ Amount: $_____ per week/month/year

(__) SNAP Start Date:_____ Amount: $_____ per week/month/year

(__) WIC Start Date:_____ Amount: $_____ per week/month/year

(__) Unemployment Start Date:_____ Amount: $_____ per week/month/year

(__) Other Voluntary Support Start Date:_____ Amount: $_____ per week/month/year

Name of Provider:_____ Address:___ _____

(__) Other _____ Start Date:_____ Amount: $_____ per week/month/year

You must provide a benefit letter dated within the last 60 days for documentation that you are receiving the following: Social Security Benefits, SNAP, WIC, Unemployment and Alimony

Child Care

(__) Started Paying for Child Care	**(__) Stopped Paying for Child Care**
Paid to Name:_____	Paid to Name:_____
Address:_____	Address:_____
Amount: $_____ per week/month/year	Amount: $_____ per week/month/year
Start Date: _____	Start Date: _____

(__) I would like a copy of this form. Initial when received _____

OTHER INFORMATION TO BE REPORTED

(__) _____

_____

I certify that all the information given on this form is accurate and complete to the best of my knowledge or belief. I understand that false statements given to HCHA may be punishable under Federal Law.

**Warning: 18 U.S.C. 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000, imprisoned for not more than five years, or both.

_____ _____

Signature Date