DEPARTMENT FOR SELF RELIANCE
DIVISION OF SOCIAL SERVICES

MONTHLY CHANGE REPORT

CUSTOMER NAME: _____ **CIF NUMBER:** _____ **Call Back Telephone #**_____

All DSR benefit groups must submit this form each month to report any changes, if any, which may affect their eligibility. **Please complete, sign and return this form by the fifth (5th) day of each month.** If the DSR Office is closed on the 5th, this form must be submitted on the first working day after the 5th. If you do not submit a Monthly Change Report (MCR), we will be unable to verify your eligibility and you will not receive your next monthly assistance payment. **Please answer all questions and sign and date the form.**

Check one box for each question and, if there was a change, provide requested information.

1) Did your contact number, email address, physical address, or mailing address change in the last 30 days?
☐ **NO** ☐ **YES** **(IF "YES", complete below)**

New contact number	New mailing address:	New email address
New Physical Address:		**Date Moved:**

2) Did you or any member in your household work part-time/full-time in the last 30 days? ☐ **NO** ☐ **YES**
(IF "YES", complete below and attach pay stubs or other proof of earnings)
If self-employed, complete DSR Self Employment Worksheet.

	Who received Income?	Hourly Rate $	Type of Employment	Frequency of pay	Gross Amount $	Check Date
INCOME #1			☐ Full-time ☐ Part-time ☐ Self-employment	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Daily		
	Business Name/Address				Net Amount $	
INCOME #2	Who received Income?	Hourly Rate $	Type of Employment	Frequency of pay	Gross Amount $	Check Date
			☐ Full-time ☐ Part-time ☐ Self-employment	☐ Monthly ☐ Weekly ☐ Bi-weekly ☐ Daily		
	Business Name/Address				Net Amount $	

3) Did you or any member in your household receive unearned income or benefits from any other source in the last 30 days? ☐ **NO** ☐ **YES** **(IF "YES", complete below and provide proof)**

Examples: Per Capita, Child Support, Alimony support, interest or dividends; gambling/lottery winnings; insurance/legal settlements; Social Security, Supplemental Security Income (SSI), Unemployment, Worker's Compensation, Royalty, Disability payments, Retirement benefits, LIHEAP etc.

Who received Income?	Source of Income	Date Received	Net Amount
			$
			$

4) Did a household member receive any State/Tribal public assistance in the last 30 days? (Food stamps, LIHEAP, Housing, Medicaid/Medical Assistance, General Assistance, Subsidized Child Care, etc.) ☐ **NO** ☐ **YES** **(IF "YES", complete below)**

Who received assistance?	Type of assistance	Date Received	Amount/ How often?
			$
			$

5) Did anyone move into or out of your home in the last 30 days? ☐ **NO** ☐ **YES** **(IF "YES", complete below)**

Name of Person	Circle One	Date Moved In/Out	Relation to Head of Household
	Moved In Moved Out		
	Moved In Moved Out		

6) Does any Household member have a checking, savings or certificate of deposit account?
☐ NO ☐ YES (If "YES", complete below and provide current bank statement)

Who owns the Account?	Type of Account	Value of Account
		$
		$

7) In the last 30 days, has any school aged minor child(ren) been withdrawn, dropped from school or expelled?
☐ NO ☐ YES (If "YES", complete below)

Child's Name	School Name	Date(s) of Withdrawal/Dropped/Expelled	Reason for Withdrawal/Dropped/Expelled

Please provide the following information for all school age children:

Child's Name	School Name	Type of Instruction: Circle One
		Virtual Hybrid At home (Packets) In person
		Virtual Hybrid At home (Packets) In person
		Virtual Hybrid At home (Packets) In person
		Virtual Hybrid At home (Packets) In person
		Virtual Hybrid At home (Packets) In person
		Virtual Hybrid At home (Packets) In person

CERTIFICATION

I UNDERSTAND THAT:

- If there are any changes which may affect my eligibility or assistance amount, I must report the change to my local DSR Office within five (5) working days after the change occurs. The information I report may result in an increase, decrease, or termination of my assistance.
- If I knowingly and willfully give false information, or do not report changes, in order to receive or continue receiving DSR assistance, my assistance will be terminated and I may be subject to legal prosecution. A Fraud conviction in a court of law, or determination by DSR Fraud Investigation Unit that I committed an Intentional Program Violation (IPV), will result in the discontinuance of future assistance from the Department for Self Reliance.
- A complete and signed Monthly Change Report Form is due by the 5th day of each month. If I do not answer all questions, do not sign the form or do not attach Verification documents for reported changes, my Monthly Change Report form will be considered incomplete. If I do not submit a complete and signed Monthly Change Report form, I will not get my monthly assistance payment.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE NAVAJO NATION THAT THE FACTS CONTAINED IN THIS REPORT ARE TRUE AND CORRECT. IN ADDITION, I CERTIFY THE ATTACHED DOCUMENTS ARE TRUE COPIES OF THE ORIGINAL DOCUMENT.

Head of Household's Signature	Date Signed
Spouse's Signature (If Applicable)	Date Signed

TO BE COMPLETED BY DSR

SUBMITTED: ☐ In Person ☐ By Mail ☐ By FAX ☐ By Drop Box ☐ By Email ☐ By phone

RECEIVED BY: _____ ☐ Complete ☐ Incomplete

FORWARDED TO: _____ Date: _____

REVIEWED BY SCW/PCW_____ FOR THE BENEFIT MONTH OF: _____
(month/year)

DEPARTMENT FOR SELF RELIANCE
DIVISION OF SOCIAL SERVICES
Work Participation Time Sheet

Name:_____ **CIF:**_____ **Case Type:**_____ **Month/Yr:**_____

Authorized Work Activities Weekending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Weekending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Weekending: _____	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Weekending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

Authorized Work Activities Weekending: _____	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Worksite Verification

I certify the information provided is accurate and true. I understand this information is subject to verification by the Department for Self Reliance and, if I do not meet the minimum work participation hours requirement, my monthly assistance amount may be reduced or my case may be closed.

Customer Signature: _____ Date:_____

Date Received: _____ Hours Entered By/Date_____

Reviewed By: _____ Total WP Hours:_____ Weekly Average: _____ WP Code: _____

THE NAVAJO NATION

DEPARTMENT FOR SELF RELIANCE

DIVISION OF SOCIAL SERVICES

Self-Employment Worksheet for the month of: ________________

CUSTOMER'S NAME:	CIF:

DAY	HOURS WORKED	GROSS INCOME	DSR USE ONLY	
			20% DEDUCTION	NET INCOME
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$

TOTAL DAYS	TOTAL HOURS	TOTAL GROSS INCOME	TOTAL DEDUCTIONS	TOTAL NET INCOME
		$	$	$

CUSTOMER SIGNATURE:	DATE:
DSR STAFF SIGNATURE:	DATE: