Reset Form

CCDF/OMW REPORT OF CHANGE

State Form 52960 (R / 12-21)
FAMILY AND SOCIAL SERVICES ADMINISTRATION

INSTRUCTIONS: Failure to report service need changes with TEN (10) calendar days may result in termination of services and you will be required to repay funds to the State of Indiana. You must report when you are no longer employed, no longer enrolled in school/training program or no longer participating in the IMPACT program, any family status change and change in address.

APPLICANT INFORMATION

Name of parent *(printed)*	
Date of Birth *(month, day, year)*	Telephone Number
Signature	Date *(month, day, year)*

SELECT FROM THE FOLLOWING

☐ My job or school/training ended on _____ *(month, day, year). Please check one of the following:*

- ☐ I do not have a new activity and would like to request transitional care *(additional documentation may be required).*
- ☐ I have started a new activity as of _____ *(month, day, year)* at _____*(location).*

☐ I would like to request additional hours for childcare. (*Please provide current school schedule or previous 30 days paystubs.)*

☐ My income has decreased, and I would like to request a reduction in copay. *(Please provide documentation of previous thirty [30] days income including wages, child support and any other income coming into the household.)*

☐ I adopted my foster child _____ *(child's name)* on _____ *(month, day, year).*

☐ Please close my case. I no longer need childcare assistance as of _____ *(month, day, year).*

☐ A family member has left / entered my home.

Name of person: _____ Date of birth *(month, day, year)*: _____

Relationship to me: _____ Is childcare needed for this individual? ☐ Yes ☐ No

☐ I am changing to a new childcare provider. *(A New Provider form must be completed by the provider and submitted with this form by Thursday before 12:00 p.m. for changes to start the following Monday. Any provider changes submitted after 12:00 p.m. on Thursdays will not go into effect until the second Sunday.)*

Date to start *(month, day, year)*: _____

Name of new provider: _____

☐ I have moved. My new contact information is *(number and street, city, state, ZIP code, and telephone number)*:

_____

_____

☐ Other changes:

_____

_____