



422 Belgrade Avenue, Suite 102
North Mankato, MN 56003
Phone: 507-345-1977
Fax: 507-345-5908
Website: www.scommchra.org

CHANGE OF INCOME REQUEST FORM

Head of household name	Primary phone number
Address	

INSTRUCTIONS: Complete only the sections that are necessary to tell us how your household income has changed. To request an adjustment, you must complete this form and return it with the supporting documentation immediately after the date of the income change. See the other side of this form for the list of documents required.

What type of change?

- I am reporting an increase in household income
 I am reporting a decrease in household income

Employment/Wages: Attach pay stubs or a current letter from the employer	
Change in pay or new employment <i>Increase is for a new job, pay raise, or job position change</i>	Employment ended <i>Decrease is for a decrease in pay or loss of job</i> *Attach confirmation from the employer of your last day worked
Household Member _____	Household Member _____
Employer Name _____	Employer Name _____
Employer Phone _____ - _____ - _____	Employer Phone _____ - _____ - _____
Employer E-mail _____	Employer Email _____
Employer Fax _____ - _____ - _____	Employer Fax _____ - _____ - _____
Employer Address _____	Employer Address _____
Effective date of the change ____/____/____	Stop Date ____/____/____
Hourly Pay Rate \$ _____	Replacement Income: Circle all that apply
Hours per week _____	<input type="checkbox"/> Unemployment <input type="checkbox"/> MFIP/GA/Cash Assistance (Welfare)
	<input type="checkbox"/> Looking for Work <input type="checkbox"/> Other (specify) _____

Other Income: Check all applicable boxes, write in details, and attach statements	
<input type="checkbox"/> Child Support	<input type="checkbox"/> Pension or annuity
<input type="checkbox"/> Gifts or contributions	<input type="checkbox"/> Social Security or SSI
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Trust or retirement disbursements
	<input type="checkbox"/> V.A. benefits
	<input type="checkbox"/> Unemployment benefits
Household Member: _____	
Describe Change: _____	
New Amount \$ _____	Weekly Bi-Weekly Monthly
Start Date ____/____/____	End Date ____/____/____

I hereby authorize SCMMCHRA to verify the information provided by me on this form and certify the information provided above is accurate and complete to the best of my knowledge. I understand that providing false information is punishable under Federal and State law and is grounds for termination of my housing assistance. I understand that if this form is not completely filled out and/or supporting documentation is not attached, the review may be cancelled. I understand that such verification may include contacting any appropriate employers, governmental agencies, or individuals identified on this form.

Signature _____ Date _____



422 Belgrade Avenue, Suite 102
 North Mankato, MN 56003
 Phone: 507-345-1977
 Fax: 507-345-5908
 Website: www.scommchra.org

CHANGE OF INCOME REQUEST FORM

Required Documents

You must attach applicable documents to ensure the HRA can process your request.

All documentation needs to have a name and date.

Type of Income Change	Required Documents
New Job(s)	Letter on employer's letterhead that includes hire date, rate of pay, hours worked per pay period OR pay stubs from 2 consecutive full pay periods
Loss of Job(s)	Letter on employer's letterhead stating the stop work date Unemployment award letter or unemployment denial letter
Change in MFIP/GA/MSA/Cash Assistance	Benefit Statement
Change in Child Support	3 months Benefit Payment History
Social Security	Award letter or Benefit Statement

IMPORTANT NOTE: A decrease request received by end of business day on the 15th of the month will be effective on the first day of the month following the month in which the change was requested. The change will only go into effect if all required documentation is received by the last 5 business days of the month the change was requested. Change requests received after the 15th of the month will be processed the first day of the 2nd month.

Upon request, SCMMCHRA will provide reasonable accommodations to people with disabilities or for those in need of interpretation services so they can participate in our programs. Please contact our office at 507-345-1977.

For Office Use Only:
