Department of Public Health and Social Services
DIVISION of CHILDREN'S WELLNESS
BUREAU of CHILD CARE SERVICES
130 University Drive Rm.15 • Mangilao, Guam 96913
Telephone 735-7344 / 7256 • Fax735-7165

CHANGE REPORT

Receptionist:_____
Date:_____

Case Name:	Eligibility Specialist:
Case Number:	Daytime Phone Number(s):

ALL CHANGES MUST BE REPORTED WITHIN TEN (10) CALENDAR DAYS

❑ NAME *(Attach marriage, divorce or other court document, or Naturalization Certificate)*

Member's name changed from _____
to_____effective _____

❑ INCOME *(Attach VOE, check stubs, termination letter, or other court document)*

Member's pay [ ] increased [ ] decreased When:_____Amount:_____

Received money for [ ] child support/alimony When:_____Amount:_____

Member [ ] found a job [ ] quit a job [ ] laid-off [ ] terminated
Who:_____When:_____Amount:_____

❑ HOUSEHOLD SIZE *(Attach Mayor's verification, birth certificate, picture ID, SS#, immunization card(s), court order, death certificate, obituary, or statement from head of household)*

Person(s) moved in: _____
(Name & Effective Date)

Person(s) moved out: _____
(Name & Effective Date)

Newborn: _____
(Name & Effective Date)

Death: _____
(Name & Effective Date)

❑ ADDRESS *(Attach Mayor's verification, utility bills, lease agreement)*

New Mailing Address: _____
New Residence Address: _____
New Telephone Number: (Home)_____(Work)_____(Other)_____

❑ CHILD CARE ARRANGEMENT *(New Provider must complete pages 3 & 4 of Child Care Application)*

Name of Child(ren)	Child Care Need *Days, Time & Effective Date*	Provider Name	Rate/Charges *indicate if increase or decrease / amount & effective date*

❑ OTHER CHANGES *(Please indicate in the space below and attach or bring supporting documents)*:

_____
_____

I HEREBY ACKNOWLEDGE THAT ALL INFORMATION GIVEN BY ME IS TRUE, CORRECT, AND COMPLETE.

_____ _____
SIGNATURE DATE