

**INSTRUCTIONS**  
**DHS 1179A (02/2023)**

**CHANGE OF CIRCUMSTANCE REPORT FORM**

**PURPOSE:**

The DHS 1179A, Change of Circumstance Report form shall be used by the Primary Individual or Authorized Representative, Legal Guardian, Power of Attorney or Conservator of the Primary individual for the case to report changes and to provide information which may affect the eligibility of the household. Such information may include, but is not limited to interpreter request; name change, address, telephone number, report of pregnancy or termination of pregnancy, third party liability (TPL) coverage, add or delete a household member including birth or death; and income.

**GENERAL INSTRUCTIONS:**

1. Use a separate form if more than one (1) household member needs to be added or if any additional information needs to be reported than spaces available.
2. Information provided on this form by the beneficiary or authorized/legal representative on behalf of the client shall be entered on the appropriate KOLEA screen(s) and file/scan form to the case record.
3. Information asked for on this form must be completed and signed by the beneficiary or authorized/legal representative. Authorized/legal representatives must have the proper authorizations to sign, receive copies, act on behalf, complete & submit information on behalf of beneficiaries.
4. Reporting of changes that affect Medicaid eligibility must be reported with ten (10) calendar days of the event. A beneficiary may report changes in person, by completing this form, or by telephone, via KOLEA client portal account, United States Postal Service, or by any other available electronic means.
5. The Department will obtain information to verify eligibility with electronic databases including but not limited to the Internal Revenue Service, Social Security Administration, Department of Homeland Security or a consumer reporting agency including existing federal and state databases. If information cannot be obtained electronically or is not reasonable compatible, the Eligibility Worker may request proof of information.
6. The effective date of redetermination due to a change of circumstance will be the date this form is received or the date it is reported to the Department by any other means unless specifically stated.
7. Retroactive medical assistance requests of an individual residing in the household that is now requesting medical assistance that received any medical services in the past ten (10) calendar days or in the past three (3) months if requesting long-term care services, a completed DHS 1100 Application for Health Coverage must be received in order for those services to be considered for that period.

**SPECIFIC INSTRUCTIONS:**

**Beneficiary, authorized representative, legal guardian, power of attorney, or conservator to complete:**

1. The Primary Individual name and identifying information shall be entered.
  - a. If an Authorized Representative, Legal Guardian, Power of Attorney or Conservator of the primary individual is reporting a Change of Circumstance on behalf of the primary individual.

Check the appropriate box indicating type of authorization, if an authorized form is on file or is being attached and enter the name of the authorized individual.

- If the Department does not have an authorized representative on file or if it has changed please have the primary individual complete form DHS 1121 "Designate Authorization Representation" form authorizing an individual to act on their behalf to assist with an application, a redetermination of eligibility and other on-going communications with the Department and attach to this form.
- If legal authorization exists or if it has changed and the Department does not have it on file, attach a copy of the legal authorization.
- Reporting of changes made by an individual that has not been authorized by the beneficiary will not be accepted without authorization.

2. The Primary Individual or authorized/legal representative shall complete the section(s) pertinent to the change(s) being reported.

a. Section 1: Terminate Medical Assistance Case: Enter the date of termination and reason.

- All household members on the case will be terminated. If you only need to terminate specific household members, complete Section 6 to request delete from household instead.

b. Section 2: Name Change: Enter "From" as the current name and "To" as the new name.

- Attach a copy of the legal name change document. Complete Section 5 (if applicable) for change in household member(s).

c. Section 3: Address &/or Telephone change.

- All household members on the case will be affected. If only specific household members have this change, complete Section 9 to indicate specific household members.

d. Section 4: Report or Change of Pregnancy: Self-explanatory.

e. Section 5: Other Health Coverage: Self-explanatory

- Attach a copy of the insurance card(s) if available.

f. Section 6: Change in Household Member(s). Enter appropriate information for any individual(s) who moved in or out of the household, is now requesting medical coverage, changed tax dependent(s) status &/or tax filer status.

g. Section 7: Report or Change in Income: Enter the name and identifying information of the individual with the change. Check whether change is to current income or to add income and enter all appropriate information.

h. Section 8: Coverage for Aged, Blind or Disabled Household Members: Enter appropriate information for the individual(s) who are requiring long-term care services or have a disability lasting more than 12 months. Include asset information for the spouse, if applicable, in Section B.

i. Section 9: Other changes: Self-explanatory.

3. Signature & Date is required to certify the information reported.

4. The DHS 1179A shall be submitted to any Med-QUEST office.

**Eligibility Worker to complete:**

1. The Eligibility Worker (EW) shall review the DHS 1179A and make a redetermination of eligibility based on the reported information or as received via electronic data matching including existing federal and state agency databases. If any missing/incomplete information is needed and cannot be obtained electronically or if information reported is not reasonable compatible with information obtained electronically, the EW shall issue a fifteen (15) day pending notice requesting only the information needed to make a redetermination or is directly connected to the State plan.
2. A DHS1100-Application for Health Coverage that requests medical assistance for a period prior to the date of a reported change in circumstance shall be considered for the ten (10) calendar days prior to the date the DHS 1100 form is received by the Department or if applying & eligible for long-term care services in the past three (3) months prior to the application received date.
3. EW shall use "DHS/MQD Use Only" box to record date action taken. File/scan the completed DHS 1179A form to the case record. The "Official Use Only" box shall be used to identify the proper case and effective date of change.