# Bread for the City Address Change / Move Report

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|  |  |  |
| **RE**:  |  | **SSN:**   |  |
|  | Name of Beneficiary/Recipient |  | Claim number(s) |
|  |  |  |  |
| **Change of Address:** |  |  |  |
| *Residential* |  | Telephone: |  |
|  |  |  |  |
|  |  | Date of  |  |
|  |  | move: |  |
| Mailing |  |  |  |
| 🞎 Same as |  |  |  |
| Residential |  |  |  |
|  |  |  |  |
|  |  |  |  |  |  |
| **This Is A:** |  |  |  |
| 🞏 | CRF\* | 🞏 | House | 🞏 | Shelter |
| 🞏 | Room | 🞏 | Hospital |  |
| 🞎 | Apartment | 🞏 | Other: |  |
| \* Additional form documenting CRF residence must be submitted to request SSI State Supplement. |
|  |
| **Consumer Lives With:** | List ALL other household members, except if Group Home or CRF |
| 🞎 | Alone | Name | Relationship |
| 🞏 | With relative(s) 🡪 |  |  |
| 🞏 | With someone else 🡪 |  |  |
| *continue in Remarks if needed* |  |  |
|  |  |  |  |
| **Rental Information:** |  |  |  |
|  |
| Landlord: |  | Rent Amt: |  |
| Address: |  | Phone: |  |
|  |  |  | \*subsidized |
|  |

**REMARKS/ADDITIONAL INFO:**

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|  |
| **Printed Name of Person Completing Form** |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Signature, Clinical Team Member** |  | **Signature, Clinical Team Supervisor** |
|  |  |  |
| **Email/phone** |  | **Provider Agency** |

Please note that if consumer is living with others or renting a room in someone’s home (esp. with a relative) additional documentation of the living arrangement may be requested.

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| **Reported To SSA By:** | Lauren Taylor | Phone: | (202) 386-7016 |