

## Change of Address Request

By changing the address, all communication regarding the Assistance Agreement will be made **only** to the payee at the identified address. If the party who is not the payee needs information regarding the Assistance Agreement, the party may contact DHS as follows:

Permanency Support Unit  
PO Box 64944  
St. Paul, MN 55164-0944  
Fax: (651) 431-7627

**Applicable child or children(add additional sheet, if needed):**

*SSN is needed for Medical Coverage **ONLY** if residing outside of Minnesota*

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**Person(s) requesting change:**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Mailing address to be used for payee:**

Street: \_\_\_\_\_ Apt/Unit# \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone number: \_\_\_\_\_

Is this an existing address? \_\_\_ Yes or \_\_\_ No

Effective date of change: \_\_\_\_\_

**Physical Address, if different from mailing address:**

Street: \_\_\_\_\_ Apt/Unit# \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip code: \_\_\_\_\_

The undersigned agree to the change of address information provided above as a modification to the Adoption Assistance Agreement. The undersigned understands that the address change may take up to **60 days** from the date the Request for Change in Payee Address form is postmarked to become effective.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Sign date

\_\_\_\_\_  
Sign date

\_\_\_\_\_  
Notary signature

\_\_\_\_\_  
Notary signature

\_\_\_\_\_  
Sign date

\_\_\_\_\_  
Sign date

Notary stamp:

Notary stamp:

***All persons currently listed on the Adoption Assistance Agreement must provide notarized signatures above.***