CCA-1235A FORPDF (11-17)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

CHANGE REPORT

PRINT NAME *(Last, First, M.I.)* _____ PHONE NO. _____

SOCIAL SECURITY NO. _____ CLIENT ID NO. _____ Phone Number New? ○ Yes ○ No

CHANGE IN ADDRESS

Has your address changed? ○ Yes ○ No *If yes, please complete this section.*

HOME ADDRESS *(No., Street)* _____

CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS *(No., Street or P.O. Box)* _____

CITY _____ STATE _____ ZIP CODE _____

YOUR EMPLOYMENT AND EARNINGS STATUS

Has your employment/earnings status changed? ○ Yes ○ No *If yes, please provide current verification.*

EMPLOYER'S NAME AND PHONE NO.	START DATE	END DATE	HOURLY WAGE	HOURS PER WEEK	HOW OFTEN PAID?
1.					
2.					
3.					

YOUR UNEARNED INCOME STATUS

Has your unearned income changed? ○ Yes ○ No *If yes, please provide current verification.*

PARENT/CARETAKER'S NAME	INCOME SOURCE	START DATE	MONTHLY AMOUNT
1.			
2.			
3.			

CHANGE IN HOUSEHOLD MEMBERS

NAME	RELATIONSHIP TO YOU AND YOUR CHILD(REN)	MOVED *(Select one)*	DATE	REASON
1.		○ In ○ Out		
2.		○ In ○ Out		
3.		○ In ○ Out		
4.		○ In ○ Out		

CHANGE IN CHILD CARE PROVIDERS

○ All Children ○ Just the Children Listed Below:	NEW PROVIDER'S NAME	PROVIDER'S ADDRESS	PROVIDER'S PHONE NO.	LAST DAY AT OLD PROVIDER	FIRST DAY AT NEW PROVIDER
1.					
2.					
3.					
4.					
5.					
6.					

CHANGE IN OTHER ELIGIBILITY FACTORS

Is there a change in medical condition, homeless/domestic violence shelter living arrangements or education and training activities *(if applicable)* for you or anyone in your household? ○ Yes ○ No *If yes, please explain:* _____

NAME OF THE AFFECTED PERSON _____ DATE _____

DESCRIPTION OF THE CHANGE _____

Statements made on this form by me or on my behalf are true and correct to the best of my knowledge. I understand that I will be responsible for any overpayments which occur as the result of submitting false information or concealing material facts in order to qualify for services, and that I may be charged with fraud pursuant to A.R.S. §13-2311, a class 5 felony.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Signature of CCA Specialist *(if information taken over phone):* _____ Date _____

See reverse for EOE/ADA/LEP/GINA disclosures

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.