

## PARTICIPANT STATEMENT VERIFICATION WORKSHEET

The statement you provide below will be used only when you have made every effort to provide documents or collateral contact information and you are unable to provide the verification to us.

Case Name \_\_\_\_\_ Date \_\_\_\_\_

AZTECS Case Number \_\_\_\_\_ APP ID: \_\_\_\_\_

### STATEMENT OF TRUTH (SIGN HERE)

Participant's Name \_\_\_\_\_ Participant's Date of Birth \_\_\_\_\_

Under penalty of perjury and acknowledged by my signature below, I swear or affirm that the statements made regarding all items that apply to my possible eligibility for benefits are true and correct to the best of my knowledge. A photocopy or facsimile (fax) of my signature shall be treated as my original signature.

Participant's Signature \_\_\_\_\_

### ABOUT MY JOB

I started working on \_\_\_\_\_ I will receive my first check on \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address (No., Street, City, State, ZIP) \_\_\_\_\_

Employer's Phone No. \_\_\_\_\_ Job Title \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

During the last 30 days I worked:

Week 1 Date: \_\_\_\_\_ for \_\_\_\_\_ hours    Week 2 Date: \_\_\_\_\_ for \_\_\_\_\_ hours

Week 3 Date: \_\_\_\_\_ for \_\_\_\_\_ hours    Week 4 Date: \_\_\_\_\_ for \_\_\_\_\_ hours

Week 5 Date: \_\_\_\_\_ for \_\_\_\_\_ hours

### ABOUT MY PAY

I make \$ \_\_\_\_\_ per hour day week.    I make \$ \_\_\_\_\_ in tips each day week.

Number of Hours Worked Per Day: (If hours vary, indicate the range possible) From \_\_\_\_\_ to \_\_\_\_\_

I am paid    Weekly    Every two weeks    Twice a month    Once a month    Other \_\_\_\_\_

I am paid on (check one):    Sun    Mon    Tue    Wed    Thur    Fri    Sat

I am paid by (check one):    Cash    Check    In exchange for \_\_\_\_\_

I am receiving:    Bonuses    Pay advances    Incentives (Explain) \_\_\_\_\_

Amount \$ \_\_\_\_\_ How Often \_\_\_\_\_

If varies give range of amount from \$ \_\_\_\_\_ to \_\_\_\_\_

I work overtime:    Yes    No    I work \_\_\_\_\_ overtime hours a week. I get paid \$ \_\_\_\_\_ an hour for my overtime.

My employer offers a health insurance plan.    Yes    No

I am enrolled in my employer's health insurance plan.    Yes    No

If Yes, complete Health Insurance information on next page.

### ABOUT MY JOB ENDING

Employer's Name \_\_\_\_\_ Employer's Phone No. \_\_\_\_\_

Employer's Address (No., Street, City, State, ZIP) \_\_\_\_\_

Department \_\_\_\_\_

Hire Date \_\_\_\_\_ My last day of work was (date) \_\_\_\_\_

I got, or will get, my final paycheck on (date) \_\_\_\_\_

The gross amount (before deductions) of my final check was \$ \_\_\_\_\_ .

Vacation pay, sick pay or extra pay included on my final check: \$ \_\_\_\_\_ .

The reason I am not working is: I quit I was fired I was laid off Other

NOTE: If you marked "I quit" or "Other reason" please explain why: \_\_\_\_\_

I did have health insurance -complete next section. Yes No

**HEALTH INSURANCE**

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy Date From \_\_\_\_\_ to \_\_\_\_\_

List others insured under this plan and their relationship to you:

**ABOUT MY CHILD SUPPORT/SPOUSAL SUPPORT**

I receive Child Support (check one): Weekly Every two weeks Twice a month  
Once a month Never Other: \_\_\_\_\_

I receive Spousal Support (check one): Weekly Every two weeks Twice a month  
Once a month Never Other: \_\_\_\_\_

When I receive support payments, I get \$ \_\_\_\_\_ in child support; I get \$ \_\_\_\_\_ in spousal support.

I receive child support for:

CHILD'S NAME	AMOUNT	FROM ABSENT PARENT

Child support payments I received in the last 3 months were:

MONTH:		MONTH:		MONTH:	
DATE	AMOUNT	DATE	AMOUNT	DATE	AMOUNT

**OTHER INCOME**

I receive income from another source not listed above:

SOURCE OF INCOME	AMOUNT RECEIVED	HOW OFTEN I RECEIVE THE INCOME
Supplemental Security Income (SSI)		
Unemployment Insurance (UI)		
Veterans Benefits		
Disability/Retirement		
Gifts/Loans		
Other:		

**HOUSEHOLD CHANGES**

HOUSEHOLD MEMBER CHANGES – Attach proof of income and resources for new members, including children and newborns. Report when someone moves in or out of your home, when a household member is in the hospital, when you or a member of your household has a baby, the death of a household member, change in your or a household member’s marital status, or if a parent is no longer disabled.

FULL NAME <i>(Last, First, M.I.)</i>	RELATIONSHIP TO YOU	DATE OF BIRTH/ DATE OF DEATH	SOC. SEC. NO. <i>(Optional if not applying)</i>	Add to your CA, NA or MA	IS PERSON	DATE MOVED
				CA NA MA	Pregnant Disabled U.S. Citizen Student Receiving Money	In:  Out:
				CA NA MA	Pregnant Disabled U.S. Citizen Student Receiving Money	In:  Out:
				CA NA MA	Pregnant Disabled U.S. Citizen Student Receiving Money	In:  Out:

**HOUSEHOLD EXPENSES**

I pay the following amount for rent, mortgage, space rent, etc.:

Amount \$ \_\_\_\_\_ How Often \_\_\_\_\_ I pay utilities: Yes No

List the utilities you pay and the monthly amount.

TYPE OF EXPENSE	COMPANY NAME	LAST BILLED AMOUNT
Electric		
Gas & Propane		
Water		
Telephone		
Coal		
Wood		
Garbage, Sewer & Trash		
Oil		

**ADDITIONAL STATEMENT**

**AGENCY USE ONLY**

FAA-0077A Due Date \_\_\_\_\_ A011/F011 Due Date \_\_\_\_\_

Result of Collateral Contact \_\_\_\_\_ Date of Collateral Contact \_\_\_\_\_

Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

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