ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

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.

See page 5 for USDA/EOE/ADA disclosures

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 *(Last, First, M.I.)*	RELATIONSHIP TO YOU	DATE OF BIRTH/ DATE OF DEATH	SOC. SEC. NO. *(Optional if not applying)*	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

How do you heat (central heating, stove, fireplace) or cool (air conditioning, evaporative cooler) your home?

_____

List the utilities you pay and the monthly amount.

TYPE OF EXPENSE	COMPANY NAME	LAST BILLED AMOUNT
Electric		
Gas & Propane		
Water		
Telephone		
Coal or 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: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.