

**ARIZONA DEPARTMENT  
OF ECONOMIC SECURITY  
Family Assistance  
Administration  
CHANGE REPORT**

**AGENCY USE**

**DATE RECEIVED:**

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**HOW RECEIVED:**

**Phone Fax Mail**

**MESSAGE RECEIVED BY:**

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**See pages 34-35 for USDA/  
EOE/ADA/LEP/GINA  
disclosures**

***You only need to complete the sections that apply to the change(s) you are reporting.***

**To report changes in your household circumstances, complete and return or fax this form and any proof of the change(s) to (602) 257-7031 when faxing from area codes 602, 480, or 623; or 1-844-680-9840 when faxing from any other area code.**

**You can also provide proof of your changes to the FAA office. To add a program to your existing case, visit any Department of Economic Security/ Family Assistance Administration (DES/ FAA) or Tribal Temporary Assistance for Needy Families (TANF) office. A list of FAA offices can be found at <https://eol.azdes.gov>. You can also apply online at [www.healthearizonaplus.gov](http://www.healthearizonaplus.gov)**

**or calling 1-855-HEA-PLUS (1-855-432-7587).**

- **Standard Reporting**
  - **Nutrition Assistance (NA), Cash Assistance (CA/TANF) – You must report changes before the 10<sup>th</sup> calendar day of the month following the month the change occurs.**
  - **Insurance/Medical Assistance (MA) – You must always report within 10 calendar days of the day you**

**know about the change. Complete the sections that apply to the change(s) you are reporting.**

- **Simplified Reporting – During your approval period for NA and/or CA, you only have to report when your gross earned and unearned income (before deductions) is more than the income limit for your NA and/or CA family size (see *the charts listed in***

***the publication, "Your  
Change Reporting  
Requirements"  
PAF-558).***

**NAME (*Last, First, M.I.*):**

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**CASE NO.:**

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**SOCIAL SECURITY NO.:**

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**DATE OF CHANGE:**

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**NEW ADDRESS/PHONE  
NO. CHANGES – *Attach  
proof of new rent,  
mortgage amounts and  
new utility costs.***

**HOME ADDRESS (*No.,  
Street, City, State, ZIP  
Code*):**

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**HOME OR MESSAGE  
PHONE NO.:**

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**MAILING ADDRESS, IF  
DIFFERENT FROM ABOVE**

***(P.O. Box, Apt./Space #  
/ No., Street, City, State,  
ZIP Code):***

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**COUNTY YOU LIVE IN:**

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**DATE OF COST CHANGE:**

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**NEW RENT OR HOUSING  
COST: \$** \_\_\_\_\_

**I PAY FOR:      Water**  
**Phone      Electric**  
**Gas      Other      None**



**HEATING AND COOLING**

**SOURCE: A/C**

**Evaporative Cooler**

**Central Heating**

**Space Heater      Other**

**LANDLORD'S NAME:**

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**LANDLORD'S ADDRESS**

***(No., Street, City, State,  
ZIP Code):***

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**PHONE NO.:**

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# **INCOME CHANGES – *Attach proof***

**EARNED INCOME – The payment you receive from working at a permanent or temporary job, any odd jobs, self-employment, babysitting, tips, etc., is earned income. If you receive Nutrition Assistance (NA) ONLY, and are assigned to the Standard Reporting requirement, you must report changes in earned income of more than \$100 a month.**

<b>NAME OF PERSON RECEIVING INCOME</b>	<b>EMPLOYER'S NAME AND ADDRESS</b>	<b>EMPLOYER'S PHONE NO.</b>	<b>DID INCOME</b>
			<b>Start Stop Change Date:</b>
			<b>Start Stop Change Date:</b>
<b>NEW HOURLY PAY</b>	<b>TIPS PER WEEK</b>	<b>HOURS PER WEEK</b>	<b>HOW OFTEN PAID</b>
<b>\$</b>	<b>\$</b>		
<b>\$</b>	<b>\$</b>		

**UNEARNED INCOME –**  
**The payment you receive from unemployment benefits, veterans' benefits, disability, retirement/pensions, gifts, contributions, child/spousal/medical support, SSA, SSI, BIA assistance, money from roomers or boarders, educational income, winnings, land lease, interest, free housing or utility allowance, etc., is unearned income.**

**If you receive Nutrition Assistance (NA) ONLY, and assigned to the Standard Reporting requirement, you must report changes in unearned income of more than \$50 a month.**

<b>NAME OF PERSON RECEIVING INCOME</b>	<b>DID INCOME</b>	<b>TYPE OF INCOME</b>	<b>AMOUNT RECEIVED</b>
	<b>Start</b> <b>Stop</b> <b>Change</b> <b>Date:</b>		   <b>\$</b>
	<b>Start</b> <b>Stop</b> <b>Change</b> <b>Date:</b>		   <b>\$</b>
<b>HOW OFTEN RECEIVED</b>	<b>CONTACT PERSON</b>		<b>PHONE NO.</b>

**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.***

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



# **FEDERAL TAX FILING CHANGES**

**Anyone plan to file  
Federal Income Taxes?**

**Yes      No**

**If yes, who?**

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**Will claim dependents  
on own tax return?**

**Yes      No**

**If yes, list dependents'  
names:**

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**Claimed as dependent  
on someone else's tax  
return?      Yes      No**

**If yes, name of tax filer  
claiming this person:**

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**FILING STATUS:**

**Head of Household**

**Qualifying Widow(er)**

**Single**

**Married-Filing**

**Separate Return**

**Married-Filing Joint**

**Return (*Spouse's***

***Name*):**

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**RESOURCE CHANGES –  
*Attach proof.* You must report all resources that reach or exceed the resource limit for the benefits your household is receiving: \$2,000 for Cash Assistance or \$2250 for Nutrition Assistance, or \$3,500 for Nutrition Assistance households with at least one member age 60 or older; \$1,000 single, or \$1,400 two or more for State Assistance.**

**NAME OF PERSON (*Last, First, M.I.*):**

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**NAME OF BANK/  
CREDIT UNION/SAVING  
AND LOAN:**

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**WHAT HAS CHANGED?  
(*Check all that apply*)**

**New Account**

**Closed Account**

**Deposit**

**Withdrawal**

**Cash**

**Checking**

**Savings**

**Stocks/Bonds**

**IDA**

**Other**

**ACCOUNT NO. (*If checking, savings or IDA*):** \_\_\_\_\_

**AMOUNT: \$** \_\_\_\_\_

**DATE OF CHANGE (*Checking, savings, other*):** \_\_\_\_\_

**DATE IDA OPENED OR CHANGED:** \_\_\_\_\_

**Complete the boxes below if anyone in your household received, bought, sold, traded or gave away any vehicle, RV, ATV or property.**

**NAME OF PERSON**  
***(Last, First, M.I.):***

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**TRANSACTION:**

**Received                      Bought**  
**Sold                      Traded**  
**Gave away                      Gift**

**DESCRIPTION OF**  
**VEHICLE, RV, BOAT OR**  
**PROPERTY:**

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**CURRENTLY**

**REGISTERED:                      Yes                      No**

**CURRENT VALUE:**

**\$** \_\_\_\_\_

**AMOUNT PAID:**

**\$** \_\_\_\_\_

**AMOUNT OWED:**

**\$** \_\_\_\_\_

**DATE OF CHANGE:**

\_\_\_\_\_

**EXPENSE CHANGES –**  
***Attach proof.* Report**  
**changes in the amount**  
**of monthly dependent**  
**care expenses you are**  
**billed for the care of a**  
**child or disabled adult**  
**in order for you to**  
**work, seek work, attend**  
**training or school. For**  
**Nutrition Assistance**  
**households ONLY – if**  
**you pay court ordered**  
**child support, you must**  
**report changes of \$50**  
**or more in the amount**  
**of your court ordered**  
**monthly child support.**



TYPE OF EXPENSE	DID EXPENSE		MONTHLY AMOUNT	
			Billed	Paid
Child Support Dependent Care Medical	Start Change Date:	Stop	\$	\$
Child Support Dependent Care Medical	Start Change Date:	Stop	\$	\$
<b>NAME OF PERSON(S) OR COMPANY(IES) YOU OWE OR HAVE PAID FOR THIS EXPENSE</b>	<b>PHONE NO.</b>		<b>NAME OF PERSON(S) RECEIVING CARE (Last, First)</b>	

**CHANGES IN SCHOOL ATTENDANCE – *Attach proof.***  
**You must report changes in school attendance for any person in your household.**

<b>NAME OF PERSON</b> <i>(Last, First, M.I.)</i>	<b>NAME OF SCHOOL AND PHONE NO.</b>	<b>TYPE OF CHANGE</b>	<b>DATE OF GRADUATION</b>
		<b>Start School</b>  <b>Stop School</b>	
		<b>Start School</b>  <b>Stop School</b>	

# **CONTINUATION OF CHANGES**

**Will the changes you are reporting continue next month?    Yes    No**

***If no, please explain:***

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**IMPORTANT  
INFORMATION,  
PLEASE READ**

**If you purposely hold  
back information about**

**changes in your household or give false information, you will owe the Arizona Department of Economic Security the value of any extra benefits you should not have received.**

**You may be subject to penalties and/or criminal prosecution under state and federal law.**

- **FOR NUTRITION ASSISTANCE. If you or any member of your family are found guilty of an intentional**

**program violation, you will be disqualified for 12 months for the first offense 24 months for the second offense and permanently for the third offense and may be subject to further prosecution under other state and federal laws. You or that person also may be fined up to \$250,000, imprisoned up to 20 years, or both; and barred by a court from the Nutrition Assistance program for**

**an extra 18 months.**

- **FOR CASH ASSISTANCE. If you or any member of your family are found guilty of an intentional program violation, you will be disqualified for 12 months for the first offense, 24 months for the second offense and permanently for the third offense and may be subject to further prosecution under other state and federal laws.**

- **FOR MEDICAL ASSISTANCE. You must not knowingly withhold or give false information with the intent to receive or continue to receive Medical Assistance. If the information you provide is incorrect, Medical Assistance may be denied or stopped. If you and/or your representative are found guilty of knowingly giving false information, you and/or your representative**

**will be subject to criminal prosecution, which could result in fines, imprisonment and/or other penalties under state or federal law. You may also be required to repay AHCCCS the amount of benefits paid during the period of ineligibility.**

**Information provided on this form may increase, decrease, suspend or stop your Nutrition Assistance, Cash Assistance or Medical**



**Assistance. A separate notice will be sent.**

**PLEASE SIGN AND DATE THIS FORM BEFORE RETURNING**

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**CHANGES REPORTED BY:**

\_\_\_\_\_  
**ACTION REQUIRED:**

**FS CA GA MA**

**NO ACTION REQUIRED:**

**FS CA GA MA**

**EI'S COMPLETION DATE:**

\_\_\_\_\_

**EI'S INITIALS: \_\_\_\_\_**

**The USDA is an equal opportunity provider and employer • DES/ TANF Agencies are Equal Opportunity Employers/ Programs • 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 your local office; 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.**