### Change Report

Use this form to report changes in your household circumstances. Complete and return this form with any proof of the changes by mail to: Department of Economic Security P.O. Box 19009, Phoenix, AZ 85005-9009, by fax to (602) 257-7031 when faxing from area codes 602, 480, or 623; or when faxing from any other area code use 1-844-680-9840, or call Customer Service at 1-855-HEA-PLUS (1-855-432-7587). You may also report changes online at <a href="https://www.Healthearizonaplus.gov">www.Healthearizonaplus.gov</a>, or call Customer Service at 1-855-HEA-PLUS (1-855-432-7587) for assistance.

Cash Assistance (CA) and Nutrition Assistance (NA) – All changes must be reported no later than the 10<sup>th</sup> calendar day of the month following the month the change occurs.

**Medical Assistance (MA)** – All changes must be reported within 10 calendar days from the day you know about the changes.

#### **Simplified Reporting Households Standard Reporting Households** CA participants must report the following changes: MA & CA TPEP participants must report the following changes: • When your household's income exceeds 36% of the 1992 Federal Poverty Level (FPL) (A1 Payment All income for everyone in the household (earned and Standard). unearned) • When a dependent child moves out or is removed from · Address, including any resulting changes in housing the household by a government agency. costs Household members (persons moving in or out) NA participants must report the following changes: · Marital status • When your household's income exceeds 130% of the current FPL. School attendance (CA only) Lottery and gambling winnings of \$4,500 or more in a Resources single game. Simplified Reporting does not apply to MA & CA Able Bodied Adult Without Dependents (ABAWD) – Must report when their work hours fall below 20 hours per week, averaged monthly.

Identifying Case Information					
Case Name (Last, First, M.I.):		Date of Change:			
AZTECS Case No: HEAplus	Application ID:	Social Security No:			
New Address Changes (Attach Proof of New Rent, Mortgage Amounts, and New Utility Costs)					
Home Address (No., Street, City, State, ZIP C	code):				
Mailing Address, If Different From Above (P.C	., Apt/Space#/No., Stree	et, City, State, ZIP Code):			
County You Live In:	Ho	me or Message Phone No:			
Landlord's Name & Phone No:					

## Expense Changes (Attach Proof)

Did any of your household's expenses change such as monthly rent, mortgage, utilities, dependent care expenses, etc. For Nutrition Assistance Households – If you are 60 years or older or have a disability and have out of pocket medical expenses of \$35.01 or more.

Please complete the Expense Changes section below with the new shelter and utility costs.

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Name of Person with the Expense	Type of Expense	Amount	Date of Change

List what is being used to heat (central heating, stove, fireplace,) or cool (air conditioning, evaporative cooler) your home:

# Household Member Changes (Attach Proof of Income or Resources For New Members, Including Children and Newborns)

**Report changes when:** someone moves in or out of your home, a household member is in the hospital, you or a member of your household has a baby, the death of a household member, a change to a household member's marital status, a parent no longer has a disability, etc.

Full Name (Last, First, M.I.)	Relationship to You	Birth Date/ Date of Death	Soc. Sec. No. (Optional if not applying)	Add to Your	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:

### **Income Changes (Attach Proof)**

Have there been changes in the income members of your household receive? Income changes from working at a permanent or temporary job, any odd jobs, self-employment, babysitting, tips, bonuses, in-kind income, unemployment benefits, veterans' benefits, disability, retirement/pensions, gifts, contributions, child/spouse/medical support, SSA, SSI, BIA Assistance, money from roomers or boarders, educational income, land lease, interest, housing assistance or utility allowance, winnings (including substantial lottery or gambling), etc.

Name of Person Receiving Income	Source (If Earned, List Name of Employer and Phone Number)	Amount (Before Deductions)	How Often is it Received?	Date of Change	Start/ Stop/ Change	
Federal Tax Filing Changes						

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Does anyone plan to file Federal Income Taxes?	Yes	No
f yes, who?		
Are you planning to claim any dependents on your own tax return?	Yes	No
f yes, list names of dependents:		
Will you be claimed as dependent on someone else's tax return?	Yes	No

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Signature: \_\_\_\_\_ Date: \_\_\_\_

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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 <a href="https://www.usda.gov/sites/default/files/documents/ad-3027.pdf">https://www.usda.gov/sites/default/files/documents/ad-3027.pdf</a>, 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

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