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 NO

_____

APP ID _____

See page 25 for USDA/EOE/ADA/ LEP/GINA disclosures

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.

I am paid

☐ **Weekly** ☐ **Every two weeks**

☐ **Twice a month** ☐ **Once a month**

☐ **Other _____**

Number of Hours Worked Per Day ***(If hours vary, indicate the range possible)*** **From _____ to _____**

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 page eight.

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 reason**

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/ALIMONY

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's Name

_____

Amount $ _____

From Absent Parent

_____

Child's Name

_____

Amount $ _____

From Absent Parent

Child's Name

Amount $

From Absent Parent

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

MONTH

Date

Amount $

Date

Amount $

Date

Amount $

Date _____

Amount $ _____

MONTH

Date _____

Amount $ _____

Date _____

Amount $ _____

Date _____

Amount $ _____

Date _____

Amount $ _____

MONTH

Date _____

Amount $ _____

Date _____

Amount $ _____

Date _____

Amount $ _____

Date _____

Amount $ _____

OTHER INCOME

I receive income from another source not listed above:

SOURCE OF INCOME

Supplemental Security Income *(SSI)*

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

SOURCE OF INCOME

Unemployment Insurance (UI)

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

SOURCE OF INCOME

Veterans Benefits

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

SOURCE OF INCOME

Disability/Retirement

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

SOURCE OF INCOME

Gifts/Loans

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

SOURCE OF INCOME

Other _____

AMOUNT RECEIVED

HOW OFTEN I RECEIVE THE INCOME

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

☐ **CA** ☐ **NA** ☐ **MA**

IS PERSON ☐ **Pregnant** ☐ **Disabled**

☐ **U.S. Citizen** ☐ **Student**

☐ **Receiving Money**

DATE MOVED

In: _____ **Out** _____

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

☐ **CA** ☐ **NA** ☐ **MA**

IS PERSON ☐ **Pregnant** ☐ **Disabled**

☐ **U.S. Citizen** ☐ **Student**

☐ **Receiving Money**

DATE MOVED

In: _____ **Out** _____

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

☐ **CA** ☐ **NA** ☐ **MA**

IS PERSON ☐ **Pregnant** ☐ **Disabled**

☐ **U.S. Citizen** ☐ **Student**

☐ **Receiving Money**

DATE MOVED

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 EXPENSES

Electric

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Gas & Propane

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Water

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Telephone

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Coal

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Wood

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Garbage, Sewer & Trash

COMPANY NAME

LAST BILLED AMOUNT

TYPE OF EXPENSES

Oil

COMPANY NAME

LAST BILLED AMOUNT

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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