# 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.**

**See pages 39-41 for USDA/EOE/ADA/ LEP/GINA disclosures**

# Case Name

# Date

# AZTECS/Case NO.

# 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** ☐ **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**

**$ _____ per 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 13.**

# 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:

# Child/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’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

**The USDA is an equal opportunity provider and employer • Equal Opportunity Employer/ Program • 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.**