ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
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,

See pages 38-44 for USDA/ EOE/ADA disclosures

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 www.Healthearizonaplus.gov or myfamilybenefits.azdes.gov. To add a program to your existing case you may apply online at www.Healthearizonaplus.gov, 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 10th 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

CA participants must report the following changes:

- **When your household's income exceeds 36% of the 1992 Federal Poverty Level (FPL) (A1 Payment Standard).**
- **When a dependent child moves out or is removed from the household by a government agency.**

NA participants must report the following changes:

- When your household's income exceeds 130% of the current FPL.
- Lottery and gambling winnings of $4,250 or more in a single game.
- Able Bodied Adult Without Dependents (ABAWD) – Must report when their work hours fall below 20 hours per week, averaged monthly.

Standard Reporting Households

MA & CA TPEP participants must report the following changes:

- All income for everyone in the household (earned and unearned)
- Address, including any resulting changes in housing costs
- Household members (persons moving in or out)
- Marital status

- **School attendance (CA only)**
- **Resources**

Simplified Reporting does not apply to MA & CA TPEP

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 Code)*:

Mailing Address, If Different from Above *(P.O., Apt/Space#/No., Street, City, State, ZIP Code)*:

County You Live In:

Home or Message Phone No:

Landlord's Name & Phone No:

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

EXPENSE CHANGES *(Attach Proof)*

Did any of your household's expenses change such as monthly dependent care expenses, rent, mortgage, utilities, 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.

Name of Person with the Expense

Type of Expense

Amount

Date of Change

Name of Person with the Expense

Type of Expense

Amount

Date of Change

Name of Person with the Expense

Type of Expense

Amount

Date of Change

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Type of Expense

Amount

Date of Change

Name of Person with the Expense

Type of Expense

Amount

Date of Change

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

☐ 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

Birth Date/Date of Death

Soc. Sec. No. *(Optional if not applying)*

Add to Your

☐ CA ☐ NA ☐ MA

Is Person

☐ Pregnant ☐ Disabled

☐ U.S. Citizen

☐ Student Receiving Money

Date Moved

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

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

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

Does anyone plan to file Federal Income Taxes?

☐ Yes ☐ No

If yes, who?

Are you planning to claim any dependents on your own tax return?

☐ **Yes** ☐ **No**

If yes, list names of dependents:

Will you be claimed as dependent on someone else's tax return?

☐ **Yes** ☐ **No**

If yes, name of tax filer claiming this person:

FILING STATUS:

☐ **Head of Household**

☐ **Qualifying Widow(er)**
☐ **Single**
☐ **Married - Filing Separate Return**
☐ **Married - Filing Joint Return**

***(Spouse's Name)*:**

CHANGES IN SCHOOL ATTENDANCE *(Attach Proof)*

For CA: Must report school attendance for children 6 to 15 years old. For NA: you may report changes in student status.

Name of Person *(Last, First, M.I.)*

Name of School and Phone No.

Type of Change

☐ Start ☐ Stop

Graduation Date – High School

Attending College

☐ Full Time ☐ Part Time

Name of Person *(Last, First, M.I.)*

Name of School and Phone No.

Type of Change

☐ Start ☐ Stop

Graduation Date – High School

Attending College

☐ Full Time ☐ Part Time

RESOURCE CHANGES *(Attach Proof)*

Did the total of your household's cash on hand, money in checking account and/or Savings account, stocks, bonds, etc. reach or exceed the resource limit for the benefits your household receives. Nutrition Assistance = $2,750, or Nutrition Assistance households that include members who are 60 years or older or have a disability = $4,250,

or Cash Assistance = $2,000.

Name of Person Receiving

Type of Resource

Amount

Date of Change

Name of Person Receiving

Type of Resource

Amount _____

Date of Change

Name of Person Receiving

Type of Resource

Amount _____

Date of Change

Will these changes continue next month?

☐ **Yes** ☐ **No**

If No, please explain:

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 possible 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 (IPV), 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 may also 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 (IPV), 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 your representative**

will be subject to criminal prosecution, which could result in fines, imprisonment, and other possible 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: _____

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.