ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

CHANGE REPORT

AGENCY USE

DATE RECEIVED:

_____

HOW RECEIVED:

☐ Phone ☐ Fax ☐ Mail

MESSAGE RECEIVED BY:

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://des.az.gov/office-locator. You can also apply online at 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 10th calendar day of the month following the month the change occurs.**
  - **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.)*:

_____

CASE NO.:

_____

SOCIAL SECURITY NO.:

_____

DATE OF CHANGE:

_____

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

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

HOME OR MESSAGE PHONE NO.:

MAILING ADDRESS, IF DIFFERENT FROM ABOVE

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

_____

_____

COUNTY YOU LIVE IN:

_____

DATE OF COST CHANGE:

_____

NEW RENT OR HOUSING COST: $ _____

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

LANDLORD'S NAME:

LANDLORD'S ADDRESS *(No., Street, City, State, ZIP Code)*:

PHONE NO.:

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.

NAME OF PERSON RECEIVING INCOME	EMPLOYER'S NAME AND ADDRESS	EMPLOYER'S PHONE NO.	DID INCOME
			☐ Start ☐ Stop ☐ Change Date:
			☐ Start ☐ Stop ☐ Change Date:

NEW HOURLY PAY	TIPS PER WEEK	HOURS PER WEEK	HOW OFTEN PAID
$	$		
$	$		

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.

NAME OF PERSON RECEIVING INCOME	DID INCOME	TYPE OF INCOME	AMOUNT RECEIVED
	☐ Start ☐ Stop ☐ Change Date:		$
	☐ Start ☐ Stop ☐ Change Date:		$

HOW OFTEN RECEIVED	CONTACT PERSON	PHONE NO.

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**	**BIRTH DATE / DATE OF DEATH**	**SOC. SEC. NO.** ***(Optional if not applying)***

Add to your CA, NA or MA	**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:**

FEDERAL TAX FILING CHANGES

Anyone plan to file Federal Income Taxes?

☐ Yes ☐ No

If yes, who?

Will claim dependents on own tax return?

☐ Yes ☐ No

If yes, list dependents' names:

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)*:**

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 and older or disabled; $1,000 single, or $1,400 two or more for State Assistance.

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

NAME OF BANK/ CREDIT UNION/SAVING AND LOAN:

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.)*:

TRANSACTION:

☐ **Received** ☐ **Bought**

☐ **Sold** ☐ **Traded**

☐ **Gave away** ☐ **Gift**

DESCRIPTION OF VEHICLE, RV, BOAT OR PROPERTY:

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 ☐ Stop ☐ Change Date:	$	$
☐ Child Support ☐ Dependent Care ☐ Medical	☐ Start ☐ Stop ☐ Change Date:	$	$

NAME OF PERSON(S) OR COMPANY(IES) YOU OWE OR HAVE PAID FOR THIS EXPENSE	PHONE NO.	NAME OF PERSON(S) RECEIVING CARE *(Last, First)*

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

NAME OF PERSON *(Last, First, M.I.)*	NAME OF SCHOOL AND PHONE NO.	TYPE OF CHANGE	DATE OF GRADUATION
		☐ Start School ☐ Stop School	
		☐ Start School ☐ Stop School	

CONTINUATION OF CHANGES

Will the changes you are reporting 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/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:

☐ NA ☐ CA ☐ TC ☐ MA

NO ACTION REQUIRED:

☐ NA ☐ CA ☐ TC ☐ MA

EI'S COMPLETION DATE:

_____

EI'S INITIALS: _____

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