

**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 38-43 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](http://www.Healthearizonaplus.gov) or [myfamilybenefits.azdes.gov](http://myfamilybenefits.azdes.gov). To add a program to your existing case you may apply online at [www.Healthearizonaplus.gov](http://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 \$4,500 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**

---

**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**

---

**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 = \$3,000, or Nutrition Assistance households that include members who are 60 years or older or have a disability = \$4,500,**

**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:**

**[FNSCIVILRIGHTS  
COMPLAINTS@usda.  
gov](mailto:FNSCIVILRIGHTS.COMPLAINTS@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.**