

**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**

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**Date**

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**AZTECS/Case NO**

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**APP ID**

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

**STATEMENT OF TRUTH (*SIGN HERE*)****Participant's Name**

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**Participant's Date of Birth**

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**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**

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**ABOUT MY JOB****I started working on**

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**I will receive my first check on**

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**Employer's Name**

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**Employer's Address (No., Street,  
City, State, ZIP)**

**Employer's Phone No.** \_\_\_\_\_

**Job Title** \_\_\_\_\_

**Name of Supervisor**

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**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**

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**I am receiving:**

**Bonuses      Pay advances  
Incentives (*explain*)**

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**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**

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**Employer's Phone No.** \_\_\_\_\_

**Employer's Address (*No., Street, City, State, ZIP*)**

**Department** \_\_\_\_\_

**Hire Date** \_\_\_\_\_

**My last day of work was *(date)***

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**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**

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**Address**

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**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**

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**Amount \$** \_\_\_\_\_

**From Absent Parent**

---

---

**Child's Name**

---

**Amount \$** \_\_\_\_\_

**From Absent Parent**

---

---

**Child's Name**

---

**Amount \$** \_\_\_\_\_

# From Absent Parent

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**Child's Name**

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**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.**

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**FULL NAME (*Last, First, M.I.*)**

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**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**

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**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**

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**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**

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# ADDITIONAL STATEMENT

**AGENCY USE ONLY**

**FA-077 Due Date** \_\_\_\_\_

**A011/F011 Due Date** \_\_\_\_\_

**Result of Collateral Contact**

**Date of Collateral Contact**

**Worker's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**SUPERVISOR SIGNATURE REQUIRED  
PRIOR TO USING PARTICIPANT'S  
STATEMENT AS BEST AVAILABLE.**

**Supervisor's Signature**

**Date** \_\_\_\_\_



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