

**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**

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**Date**

---

**AZTECS/Case NO.**

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**APP ID**

---

**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.**

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# Participant's Signature

---

## ABOUT MY JOB

**I started working on**

---

**I will receive my first  
check on**

---

**Employer's Name**

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**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*):**

<b>Sun</b>	<b>Mon</b>	<b>Tue</b>
<b>Wed</b>	<b>Thur</b>	<b>Fri</b>
<b>Sat</b>		

**I am paid by (*check one*):**

<b>Cash</b>	<b>Check</b>
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**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**

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

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**Employer's Phone No.**

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**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 \$**

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**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

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**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**

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**A011/F011 Due Date**

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**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** \_\_\_\_\_

**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**



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