FA-412-FF (7-11)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

CHANGE REPORT

You only need to complete the sections that apply to the change(s) you are reporting.

AGENCY USE
DATE RECEIVED
HOW RECEIVED
☐ Phone ☐ Fax ☐ Mail
MESSAGE RECEIVED BY

To report changes in your household circumstances, complete and return or fax this form **and provide proof** of the change(s) to your local office. You may also call *(in Phoenix)* (602) 542-9935, or toll-free *(outside Phoenix)* 1-800-352-8401. **AHCCCS Health Insurance/Medical Assistance (MA)** households are required to report all changes within 10 days of the day they know about the change (Standard Reporting). Complete the sections that apply to the change(s) you are reporting.

Nutrition Assistance (NA), Cash Assistance (CA/TANF), and State Assistance households must report changes according to the following Reporting Requirements assigned. Your change reporting requirement is listed in your approval or change letter.

- **Standard Reporting**

  CA/NA–You must report changes **before** the 10th calendar day of the month following the month the **change occurs.**

  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. *(If you receive MA, you are assigned to Standard 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. / SOC. SEC. 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, ZIP)*	HOME OR MESSAGE PHONE NO.
MAILING ADDRESS, IF DIFFERENT FROM ABOVE *(P.O. Box, Apt./Space #/No., Street, City, State, ZIP)*	COUNTY YOU LIVE IN

DATE OF COST CHANGE	NEW RENT OR HOUSING COST	I PAY FOR	I PAY FOR HEATING AND COOLING THROUGH
	$	☐ Water ☐ Phone	☐ Electric ☐ Gas ☐ Other ☐ None

LANDLORD'S NAME	LANDLORD'S ADDRESS *(No., Street, City, State, ZIP)*	LANDLORD'S 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	NEW HOURLY PAY	TIPS PER WEEK	HRS. PER WEEK	HOW OFTEN PAID
			☐ Start ☐ Stop ☐ Change Date:	$	$		
			☐ Start ☐ Stop ☐ Change Date:	$	$		

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 are assigned to the Standard Reporting requirement, you must report changes in unearned income of more than $50 a month.

NAME OF PERSON RECEIVING INCOME	TYPE OF INCOME	AMOUNT RECEIVED	HOW OFTEN RECEIVED	DATE RECEIVED	CONTACT PERSON	PHONE NO.	DATE OF CHANGE
		$					
		$					

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.)*	RELATION-SHIP TO YOU	BIRTHDATE	SOC. SEC. NO. *(Optional if not applying)*	Add to your NA or MA	Is person				Date Moved	
					Pregnant	Disabled	U.S. Citz.	Student	In	Out
				☐ NA ☐ MA	☐	☐	☐	☐		
				☐ NA ☐ MA	☐	☐	☐	☐		

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 and Nutrition Assistance, or $3,000 for Nutrition Assistance households with at least one member age 60 or older; $1,000 single, or $1,400 two or more for State Assistance. AHCCCS-MED category only, when the value of resources are more than $100,000 *(no more than $5,000 are liquid resources).*

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

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 CHANGE
		☐ 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	NO ACTION REQUIRED	EI'S COMPLETION DATE	EI'S INITIALS
☐ FS ☐ CA ☐ GA ☐ MA	☐ FS ☐ CA ☐ GA ☐ MA		