

## 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, 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 [Healtharizonaplus.gov](http://Healtharizonaplus.gov) or [myfamilybenefits.azdes.gov](http://myfamilybenefits.azdes.gov). To add a program to your existing case you may apply online at [Healtharizonaplus.gov](http://Healtharizonaplus.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 10<sup>th</sup> 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	Standard Reporting Households
<p><b>CA participants must report the following changes:</b></p> <ul style="list-style-type: none"> <li>When your household’s income exceeds 36% of the 1992 Federal Poverty Level (FPL) (A1 Payment Standard).</li> <li>When a dependent child moves out or is removed from the household by a government agency.</li> </ul> <p><b>NA participants must report the following changes:</b></p> <ul style="list-style-type: none"> <li>When the total gross monthly income of all participants included in the NA household (including disqualified members) exceeds 200% of the federal poverty level.</li> <li>Lottery and gambling winnings of \$4,500 or more in a single game.</li> <li>An <i>Able Bodied Adult Without Dependents</i> must report when their work hours fall below 20 hours per week, or an average of 80 hours per month.</li> </ul>	<p><b>MA &amp; CA TPEP participants must report the following changes:</b></p> <ul style="list-style-type: none"> <li>All income for everyone in the household (earned and unearned)</li> <li>Address, including any resulting changes in housing costs</li> <li>Household members (persons moving in or out)</li> <li>Marital status</li> <li>School attendance (CA only)</li> <li>Resources</li> </ul> <hr/> <p><b>Simplified Reporting does not apply to MA &amp; CA TPEP</b></p>

**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 rent, mortgage, utilities, dependent care expenses, etc.?** For NA, when a participant is 60 years of age or older, or has a disability and has out-of-pocket medical expenses that are more than \$35 per month, a medical expense deduction may be allowed.

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	SSN (Optional if not applying)	Add to Your	Is the Person	Date Moved
				<input type="checkbox"/> CA <input type="checkbox"/> NA <input type="checkbox"/> MA	<input type="checkbox"/> Pregnant <input type="checkbox"/> Disabled <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Student Receiving Money	In:  Out:
				<input type="checkbox"/> CA <input type="checkbox"/> NA <input type="checkbox"/> MA	<input type="checkbox"/> Pregnant <input type="checkbox"/> Disabled <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Student Receiving Money	In:  Out:

**Income Changes (Attach Proof)**

**Have there been changes in the income that 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

**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	Graduation Date – High School	Attending College
		<input type="checkbox"/> Start <input type="checkbox"/> Stop		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
		<input type="checkbox"/> Start <input type="checkbox"/> Stop		<input type="checkbox"/> Full Time <input type="checkbox"/> 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

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.**

*If you are completing this form electronically, typing your signature will constitute a valid signature.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., braille, large print, audiotope, American Sign Language) should contact the responsible State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 ( voice and TTY). Additionally, Program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:** USDA Food and Nutrition Service, 1320 Braddock Place, Room 334 Alexandria, VA 22314; or
2. **Email:** [FNCSIVILRIGHTSCOMPLAINTS@usda.gov](mailto:FNCSIVILRIGHTSCOMPLAINTS@usda.gov).

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