HCV/RAD/PBV PARTICIPANT CHANGE REPORT

All changes must be reported in writing within 10 days
If you fail to comply, you must repay any over-paid housing assistance

Head of Household (HH): _____ Last Four Digits of Social Security# _____

Phone Number:_____ E-mail:_____

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HOUSEHOLD COMPOSITION CHANGE:

Adding a New Member ☐

Name of Person:_____ Social Security Number:_____

Date of Birth: ___/___/___ Male ☐ Female ☐ Relationship to **HH**_____

Income of Person: $_____(Check one: weekly ☐, bi-weekly☐, monthly ☐)

Is the person you would like to add included in any other family receiving any type of housing assistance in Arizona or any other state? ☐YES ☐NO

You must provide Birth Certificate, Social Security Card, Proof of Income, and a letter from the landlord granting permission to add/remove this person to the lease. Persons over the age of 18 may not move in to your household until criminal history check has been completed and approved. Proof of guardianship, such as a letter from CPS, or court-awarded guardianship documentation is required if the new household member is under the age of 18. Additional documentation may be required. Adding a person does not guarantee an additional bedroom.

Removing a Member ☐

Name of Person_____ Date of Birth:_____/_____/_____ - -

You must provide proof of residency for the individual you are removing. This may be done by providing a copy of their new lease or utility bills showing their new living address.

NEW EMPLOYMENT

Household Member:_____ Start Date:_____/_____/_____

Name of Employer:_____ Contact Information:_____

Amount of Income: $_____(Check one: weekly ☐, bi-weekly ☐, monthly☐)

Attach the following:

- A letter on company letterhead singed by the employer stating income, start date, hourly rate, and the number of hours per week. A phone number must also be provided.

CHANGE IN WAGES **Effective Date** _____ ☐ **Increase** ☐ **Decrease/ Termination**

Household Member: _____

Name of Employer:_____ Contact Information:_____

Attach the following:

- Letter from your employer on company letterhead signed by the employer explaining the reason for increase/decrease, the effective or termination date, hourly rate, and the number of hours per week. A phone number must also be provided.

OVER

CHANGE IN BENEFITS

Benefit Income: Effective Date_____ ☐ **Increase** ☐ **Decrease**

Household Member:_____

Type of Benefit Income_____

Attach the following:

- Updated benefit award letter from benefit provider.

OTHER INCOME NOT LISTED: Effective Date _____

Household Member:_____ ☐ **Increase** ☐ **Decrease**

Amount of Income: $_____(Check one: weekly ☐, bi-weekly ☐, monthly ☐, lump sum ☐)

Does anyone outside of your household pay for any bills or give you money? ☐Yes ☐ No

Attach the following:

- Letter explaining any and all additional income sources on company letterhead where appropriate.

OUT OF POCKET CHILDCARE EXPENSE (Work or School Related Only): ☐ Increase ☐ Decrease

Household Member: _____Date Started: ___/___/___Date Stopped: ___/___/___

Amount of Payment: $ (Check one: weekly☐, bi-weekly☐, monthly☐)

Name of Child:_____Age of Child:_____

Attach the following:

- Letter from child care provider explaining the increase/decrease in expense, as well as the hourly rate for during the school year and the summer months.

OUT OF POCKET MEDICAL EXPENSE (Elderly/Disabled Families Only): Increase ☐ Decrease ☐

Household Member:_____Date Started: Date Stopped:_

Amount of Payment: $_____ (Check one: weekly☐, bi- weekly☐, monthly☐)

Attach the following:_____

- Letter from the appropriate agency explaining increase/decrease.
- Printout from the pharmacy or doctor showing out of pocket expenses (i.e. co-pays).

WARNING: SECTION 1001 OF TITLE 18 OF THE U.S. CODE MAKES IT A CRIMINAL OFFENSE TO MAKE WILLFUL FALSE. STATEMENTS OR MISREPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE U.S. GOVERNMENT AS TO ANY MATTER WITHIN ITS JURISDICTION. MISREPRESENTATION OF ANY INFORMATION IS GROUNDS FOR TERMINATION OF HOUSING ASSISTANCE.

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS CHANGE REPORT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT THIS REQUEST WILL NOT BE PROCESSED WITHOUT PROVIDING DOCUMENTED PROOF OF THE CHANGE.

SIGNATURE_____ **DATE**_____

For office use only: TCODE#_____ Caseworker:_____

Staff Initials:_____ Recert Date:_____