PARTICIPANT CHANGE REPORT

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

City: _____State: ____Zip: _____ Phone Number: _____

Email Address: _____

Program Type: Section 8: ☐ Public Housing: ☐ FYI ☐ EHV ☐ VASH ☐

HOUSEHOLD COMPOSITION CHANGE REQUEST:

Adding a New Member ☐ Removing a Member ☐

You must provide a Birth Certificate, Social Security Card, Proof of Income, and a letter from the landlord granting permission to add/remove this person from the lease. 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. GHA will not approve the addition of a household member to the assisted household if it would create overcrowding by HUD.

Name of Person: _____ Social Security Number: _____

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

Type of Income:_____(How often Paid: 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

CHANGE IN WAGES/ NEW EMPLOYMENT

Household Member: _____ Did Income: ☐ START ☐ STOP ☐ CHANGE IN WAGES

Type of Income: _____ Hourly Rate:$_____ (How often Paid: weekly ☐, bi-weekly ☐, monthly ☐)

Effective Date_____ ☐ Increase ☐ Decrease

Employer's Name: _____

Attach the following:

☐ A letter on company letterhead from employer stating income, start date, hourly rate, and **the** number of hours per week.

CHANGE IN WAGES

Effective Date_____ ☐ Increase ☐ Decrease ☐ Terminated/Stopped

Attach the following: ☐ Letter from your employer on company letterhead explaining the reason for increase/decrease, the effective date, hourly rate, and the number of hours per week.

OVER

CHANGE IN BENEFITS

Benefit Income**:** **Effective Date**_____ ☐ **Increase** ☐ **Decrease** ☐ **Terminated/Stopped**

Household Member: _____ Type of Benefit Income _____

Attach the following: ☐ Updated benefit award letter from benefit provider.

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 childcare 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 UNLESS ALL DOCUMENTATION IS RECEIVED BY THE 20TH DAY OF THIS MONTH, MY RENT PORTION CANNOT BE DECREASED FOR THE NEXT MONTH UNLESS ALL DOCUMENTATION IS RECEIVED BY THE 20TH DAY OF THIS MONTH.

****** I UNDERSTAND THAT I AM RESPONSIBLE TO FOLLOW-UP WITH MY HOUSING REPRESENTATIVE TO ENSURE THE REPORTED CHANGE(S) WAS RECEIVED AND PROCESSED.**

SIGNATURE _____ DATE _____

EQUAL HOUSING OPPORTUNITY