

# PARTICIPANT CHANGE REPORT

**All changes must be reported within 10 days**  
**If you fail to comply, you must repay any over-paid housing assistance**  
**Proof must be provided for any changes to be made**

Head of Household (HH): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Program Type: Section 8:  (or) Public Housing:

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**Household Composition Change: Adding a New Member  Removing a Member**

Written approval is required to add any person to the assisted family. You must provide Birth Certificate, Social Security Card and Proof of Income to add anyone to household. Adding a person does not guarantee an additional bedroom. Glendale Housing will not approve the addition of a household member to the assisted household if it would increase the number of bedrooms.

\* All persons over the age of 16 must have a criminal history check completed and approved by CHD.

\* For persons over 18 years old, you must also provide a photo ID.

Name of Person: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Male  Female  Relationship to HH \_\_\_\_\_

Income of Person: \$\_\_\_\_\_ (Check one: weekly , bi-weekly , monthly )

**Attach the following:**

- Letter on company letterhead from employer that states the start date, hourly rate, and hours worked per week.
- Birth certificate of the person whom you are requesting to **add** to the household.
- Social Security Card of the person whom you are requesting to **add** to the household.
- Letter from the landlord acknowledging that he/she is aware of the request to add/remove a person from/to the household.
- Guardianship documentation (required if member is under the age of 18). Additional documentation may be requested.

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

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**Employment / Wages:    Increase     Decrease**

Household Member: \_\_\_\_\_ Date Started: \_\_\_/\_\_\_/\_\_\_ Date Stopped: \_\_\_/\_\_\_/\_\_\_

Amount of Income: \$\_\_\_\_\_ (Check one: weekly , bi-weekly , monthly )

**Attach the following:**

- A letter on company letterhead from employer stating income, AND six weeks of the most current, consecutive paystubs.
- For new employment, the letter must include hire date, hourly rate, and hours worked per week.

**Benefit Income:** Increase  Decrease

Household Member: \_\_\_\_\_ Date Started: \_\_\_/\_\_\_/\_\_\_ Date Stopped: \_\_\_/\_\_\_/\_\_\_

Amount of Income: \$\_\_\_\_\_ (Check one: weekly , bi-weekly , monthly )

**Type of Benefit Income** \_\_\_\_\_

**Attach the following:**

- Updated benefit award letter from benefit provider.
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**Other Income Not Listed:** Increase  Decrease

Household Member: \_\_\_\_\_ Date Started: \_\_\_/\_\_\_/\_\_\_ Date Stopped: \_\_\_/\_\_\_/\_\_\_

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.
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**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.
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**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).
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**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.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_