

**HOUSING AUTHORITY OF MARICOPA COUNTY**

**REPORT OF CHANGE OF CIRCUMSTANCES**  
(Change in Family Name, Composition, Income and Allowable Deductions)

Name: _____	Date: _____
Current Address: _____	City: _____ State: _____ Zip: _____
Telephone #: _____	Message (Cell) Phone #: _____

**Family Certification:**

I understand that I am required to complete and submit this form within 10 working days of any change in my household name, composition, income and allowable deductions. All changes will require that verifications(s) be completed within 30 days of the change (indicated below). If I fail to provide notification and verification of the change in the required time frame, the Housing Authority may begin the process to terminate my housing assistance.

**Signature(s):** \_\_\_\_\_

[Warning: Title 18, Section 1001 of the United States Code states that a person is guilty of a Felony for knowingly and willingly making a false or fraudulent statement to any department of agency of the US.]

**Reported Changes:**

- Name Change                      Yes                          No
- Change in Family Members    Yes                          No      
Addition(s) \_\_\_\_\_  
(must provide proof of identity, birth certificate, social security card, etc.)  
Deletion(s) \_\_\_\_\_
- Income Change                      Yes                          No    
  - Income increased                      Yes                          No
  - Income decreased                      Yes                          NoWhat happened to cause this reported change \_\_\_\_\_  
\_\_\_\_\_

If the income change is due to new employment, please complete the following:

Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip code \_\_\_\_\_  
Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_  
# Hours per week \_\_\_\_\_ Rate of pay \_\_\_\_\_

- Deductions                                      Yes                                          No      
Childcare: (Must provide name, address and telephone # of provider)  
\_\_\_\_\_

Medical: (Only Elderly, Handicap, Disabled Families)

List nature of expense and provide name and address of provider:  
\_\_\_\_\_

For office use only: Action Taken: _____ No Action Taken: _____ Date Rec'd _____ Community Service Status Change: Yes _____ No _____
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