ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Written Statement for No Income

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

Instructions:
Use this form when an AHCCCS customer has no income reported. Providing complete information helps determine eligibility for AHCCCS Medical Assistance.

Basic Needs Information

How are your basic needs being met?

1. Current Living Situation:

2. Are you responsible for paying money to stay in your current living situation?
   - ☐ Yes - If yes, how are you paying for this?
   - ☐ No

3. Do you pay for food?
   - ☐ Yes - If yes, how are you paying for food?
   - ☐ No - If no, how do you get food?

4. Please give any additional information about how your basic needs are met:

I affirm under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information.

PRINTED NAME OF CUSTOMER OR AUTHORIZED REPRESENTATIVE	SIGNATURE OF CUSTOMER OR AUTHORIZED REPRESENTATIVE	DATE
PRINTED NAME OF WITNESS (ONLY NEEDED IF CUSTOMER SIGNED WITH MARK)	SIGNATURE OF WITNESS	DATE