ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Written Statement for Income Ended/Stopped

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

Instructions:
Use this form when an AHCCCS customer reports their income has ended. Providing complete information helps determine eligibility for AHCCCS Medical Assistance.

Employer Information	
Employer Name:	
Employer Address:	
Employer Phone Number:	
Last Day Worked:	Last Day Paid (Final Paycheck):
Do you expect any more pay (vacation, sick pay, severance)? ☐ No ☐ Yes (Explain):	

If you Cannot Get Proof From The Employer	
Reason proof cannot be provided:	
☐ Employer out of business	☐ No records
☐ Employer will not respond	☐ Other:
Explain what you did to try to get proof:	

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