Job Title of Person Completing Information

Signature of Person Completing Information

Date Signed

MAILING DATE: 10/17/14
CASE NUMBER: 03860242
NOTICE NUMBER: C005

) Yes or ✓ No

If yes,
Name of Insurance Company: _____
Address of Insurance Company: _____
Policy Number: _____
Policy Date: From _____ To _____
List Insured Dependents and Relationship to Employee:

Name	Relationship

PAYCHECK ISSUED

Please complete the following when a month and year are indicated.

Month/Year: 07/2014

Date Pay Period Ended	Date Paid	Gross Pay	Hours	Tips
		$		$
		$		$
		$		$
		$		$

Month/Year: 08/2014

Date Pay Period Ended	Date Paid	Gross Pay	Hours	Tips
		$		$
		$		$
		$		$
		$		$

Month/Year: 09/2014

Date Pay Period Ended	Date Paid	Gross Pay	Hours	Tips
		$		$
		$		$
		$		$
		$		$

Month/Year: 10/2014

Date Pay Period Ended	Date Paid	Gross Pay	Hours	Tips
		$		$
		$		$
		$		$
		$		$

THIS SECTION MUST ALSO BE COMPLETED BY THE EMPLOYER

Printed Name Person Completing Information _____ Phone Number _____

[illegible]

(Continued on the back of this page.)

☐ Yes or ☐ No
If yes, how much? $_____
How often? _____

10. Is this a decrease in the employee's wages/hours?
☐ Yes or ☐ No
If yes
Reason for the decrease? _____
_____
How long is this decrease expected to last?
_____

11. Is the employee reimbursed for (check those that apply)?
☐ Travel
☐ Lodging
☐ Uniforms
☐ Other - Please Explain: _____
If yes: How often? _____
Amount: $_____

12. Is the employee's pay check a direct deposit?
☐ Yes If yes, name of bank: _____
☐ No

13. Are the employee's wages received under the Workforce Investment Act (WIA)?
☐ Yes or ☐ No

14. Is the employee working under a contract?
☐ Yes or ☐ No
If yes,
Period of time contract covers: _____
Period of time employee is anticipated to work: _____
_____
Gross wages paid by the contract: $_____
Frequency of pay: _____
Is the contract income paid based on?:
☐ An hourly rate, or
☐ Piecemeal rate - paid based on number of items produced
If yes, Hourly rate: $_____
Per Job rate: $ _____
Other: _____

15. Are there Child Support Withholdings?:
☐ Yes or ☐ No
If yes, Amount: $_____ How often _____

16. Workers Compensation (Claim pending or claim being paid)?:
☐ Yes or ☐ No
If yes, Carrier's Name: _____

17. Are there expected changes in income?
☐ Yes or ☐ No
If yes, When: _____ and
Type: ☐ Increase, ☐ Decrease, or
☐ Other (explain): _____
Reason for change: _____

HEALTH INSURANCE INFORMATION

18. Does your company offer Health Insurance?
☐ Yes If yes, continue below.
☐ No
Does the employee have Medical Insurance?

(Continued on the next page.)

MAILING DATE: 10/17/14
CASE NUMBER: 03560242
NOTICE NUMBER: C005

I give permission to release employment and employment income information to the Department of Economic Security.

Caty Price
Please Print Your Name

Caty Price 10/21/14
Signature Date Signed

Social Security number: 601-90-9579

****
* SECTION TWO for The Employer to Complete *
****

Company name: _____
Address: _____
Company Phone Number: _____
Company FAX Number: _____

It is important the last page be completed with the employer's printed name, phone number, job title, signature and date signed.

1. Date started working: _____
2. Date of 1st pay: _____
   Actual Gross Income: $_____ or,
   Anticipated Gross Income: $_____
3. How often is the employee paid? Check the one that applies.
   - ☐ Weekly
   - ☐ Bi-Weekly
   - ☐ Semi-Monthly
   - ☐ Monthly
   - ☐ Other - Please Explain: _____
4. Employee's rate of pay. Complete the one that applies.
   - ☐ $_____ Per Hour
   - ☐ $_____ Per Week
   - ☐ $_____ Per Month
5. Day of the Week is the employee paid: _____
6. Day of the Week or Date(s) the pay period end: _____
7. How many hours does the employee work per week?: _____
   If the hours vary per week what is the average hours worked? _____
8. Is overtime expected?
   ☐ Yes or ☐ No
   If yes, how many hours are expected per week? _____
   Employee's rate of pay for overtime: $_____
9. Does the employee receive any Tips/bonus/commission/shift pay?

(Continued on the back of this page.)

Includes transportation costs to dependent care provider, after-school care, special needs care, at-risk youth programs and informal care arrangements.

IMPORTANT: The last page of the notice must be returned to us with the other pages completed by the employer with the employer's printed name, phone number, job title, signature and date signed.

-Deadline for Giving Us Your Information-

Important: We need this information no later than 10/27/2014.

-Ways to Give Us Your Information-

You can:

1. (Health-e-Arizona Plus accounts ONLY)
   You can use your on-line account to:
   * Scan and upload verification, OR
   * Print Health-e-Arizona Plus fax cover sheets and fax verification to the number on the fax cover sheet.
2. Return it by mail to: LOCAL OFFICE at:
   Department of Economic Security
   P O Box 19007
   Phoenix, AZ 85005-9007
3. FAX to (602) 257-7091 if you do not have an account with Health-e-Arizona Plus.
4. Take this to the local Department of Economic Security/Family Assistance Administration office.

-What Happens If We Do Not Get Your Information-

If you do not give us the information or ask us for help by 10/27/2014 the benefits for the program(s) listed on page 1 could be denied, changed or stopped. We will send you a separate notice if we take further actions.

WHAT YOU CAN DO IF YOU NEED HELP OR HAVE QUESTIONS

Call us at 1 (855) 432-7587. You can call us Monday through Friday, 8:00 a.m. to 5:00 p.m. The TTY/TDD number for the hearing impaired is 7-1-1.

If you need help in getting documents or other information please contact us.

VERIFICATION OF EMPLOYMENT AND EMPLOYMENT INCOME

****
* SECTION ONE to Be Completed By CODY PETRIE *
****

(Continued on the next page.)

FAMILY ASSISTANCE ADMIN
CHANGE CENTER
PO BOX 19009
PHOENIX AZ 85005

OFFICE NUMBER: (855) 432-7587
CASE NUMBER: 03860242
NOTICE NUMBER: C005
MAILING DATE: 10/17/14

SHAREE A. PETRIE
551 S ASH ST
GILBERT AZ 85233

DEAR SHAREE A. PETRIE
Este aviso se refiere a la informacion importante acerca de sus beneficios, los plazos cortos para pedir una Audiencia y la manera de seguir recibiendo beneficios si usted esta en desacuerdo con nuestra decision. Llame de inmediato al DES al 1-855-432-7587 y DES le leer n este aviso a usted en Espanol.

THIS NOTICE IS ABOUT YOUR APPLICATION OR REPORTED CHANGE WITH THE DEPARTMENT OF ECONOMIC SECURITY AND INFORMATION NEEDED

Important: We need more information about your household's income to determine if you or others persons in your household are eligible for the programs) listed below:

* AHCCCS HEALTH INSURANCE

CHANGE REPORTED TO US

On 10/16/14 you reported that CODY PETRIE started working at:
ASU

THIS IS WHAT YOU NEED TO DO

-This is the Information We Need-

- You must give us proof of income for the person listed above.
- We have provided a form on the following pages for the person listed to use to verify the employment and employment income.
- SECTION ONE is for the person listed above to complete giving the employer permission to give us the information.
- SECTION TWO is for the employer to fill out.
- Proof of all child/disabled adult care expenses paid for each child/disabled adult. For Nutrition Assistance benefits this

(Continued on the back of this page.)