DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Department of Economic Security
Family Assistance Administration
P.O. Box 19009
Phoenix, AZ 85005

Case Number: 05884556
Notice Number: F100
Notice Date: February 07, 2024
Program: Nutrition Assistance (NA)

Clayton Sowers
2806 W Cactus Rd
Phoenix, AZ 85029

NUTRITION ASSISTANCE (NA) APPROVAL NOTICE

*** We now offer all services by telephone ****

Dear Clayton Sowers,

BENEFITS APPROVED

We processed your application for Nutrition Assistance (NA) turned in on **January 08, 2024**. We have approved you for NA benefits.

You will get NA benefits from **January 2024** to **December 2024**.

YOUR BENEFITS AMOUNT

Your household will get $225.00 for **January 2024**. Starting in **February 2024**, you will get $291.00 on the 10th day of the month.

HOW TO GET YOUR BENEFITS

Your NA benefits will be placed on your Electronic Benefits Transfer (EBT) card. If you do not have an EBT card, you can call 1 (888) 997-9333 to ask for one. The TTY/TDD number for the hearing impaired is 1 (800) 367-8939.

RESTAURANT MEALS PROGRAM

Your household is eligible for the Restaurant Meals Program. This allows you to use your Electronic Benefits Transfer (EBT) QUEST card to buy prepared meals from participating restaurants and the deli section of participating grocery stores. For more information about this program and participating restaurants visit the following website: des.az.gov/services/basic-needs/food-assistance/restaurant-meals-program.

IMPORTANT – REPORTING CHANGES

You must report any changes listed below by the 10th day of the month following the month the change occurs.

- When the gross income for your household totals more than $1580 per month. Gross income is the amount of your income before any deductions.

- When you are an able-bodied adult between the ages of 18 and 52 with no dependent children, you must report if your work hours are decreased below 80 hours per month. - When any household member receives lottery or gambling winnings of $4250 or more in a single game.

HOW TO REPORT CHANGES

- Call 1 (855) 432-7587 Monday - Friday, 7:00 a.m. to 6:00 p.m.
- The TTY/TDD number for the hearing impaired is 7-1-1.
- Online at www.healthearizonaplus.gov or myfamilybenefits.azdes.gov.
- Mail your change report to PO BOX 19009, Phoenix, AZ 85005.
- Fax your change report to (602) 257-7031 or toll free to (844) 680-9840.
- In person at any Department of Economic Security Family Assistance Administration office.

MID APPROVAL CONTACT (MAC)

Since you are approved for a 12 month approval period, we will send you a Mid Approval Contact (MAC) form halfway through your approval period. You must answer all questions on the form, sign the form, and turn it in or your benefits will be stopped.

WHO IS INCLUDED IN YOUR NUTRITION ASSISTANCE HOUSEHOLD

CLIENT NAME	DATE OF BIRTH
SOWERS, CLAYTON	07/21/98

HOW YOUR MONTHLY BENEFITS WERE DETERMINED

We used your household's income of $0.00 and your household's deductions of $0.00 to figure out the NA benefits your household will get each month.

WHO TO CONTACT IF YOU HAVE QUESTIONS

- Call 1 (855) 432-7587 Monday - Friday, 7:00 a.m. to 6:00 p.m.
  The TTY/TDD number for the hearing impaired is 7-1-1.
- In person at any Department of Economic Security Family Assistance Administration office.

WHAT TO DO IF YOU DO NOT AGREE WITH THIS DECISION

You may appeal by:
- Filling out the Hearing Request form included with this notice and return it in person at any Department of Economic Security, Family Assistance Administration office. Or fax to 602-257-7058, 602-257-7056, or 602-257-7055.
- You may call (602) 771-9019 or toll free at 1 (877) 528-3330.
- Mail your request to:
  Department of Economic Security
  P O Box 19009

Phoenix, AZ 85005-9009
- Go online to www.healthearizonaplus.gov and sign into your account.

You can request your benefits to continue pending an appeal, but you may have to pay back the benefits you were not entitled to get.

FREE LEGAL HELP

You may contact COMMUNITY LEGAL SERVICES at WWW.CLSAZ.ORG or 800-852-9075.

QUALITY CONTROL REVIEW

Cases are selected for quality control review. If your case is selected, you will receive a notice from the Office of Program Evaluation to arrange an interview. If you do not comply with the review, your NA benefits may stop.

RULES WE USED TO MAKE OUR DECISION

- Who is in your household: 7 Code of Federal Regulations (CFR): section 273.1;
- Sponsor income: 7 CFR section 273.4 ©;
- Income and deductions: 7 CFR section 273.9;
- Determining household eligibility and benefit levels: 7 CFR section 273.10;
- Action on households with special circumstances: 7 CFR section 273.11;
- Changing benefits without notice if your CA or TPEP application is approved: 7 CFR section 273.13(b)(6); and
- Claims against households; overpayments: 7 CFR section 273.18.

WHERE TO FIND THE RULES

You can find these laws at any of the following:
- At a public library and
- On the Internet at ARS: www.azleg.gov/arstitle/ and CFR: www.ecfr.gov/.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to: mail: Food and Nutrition Service, USDA 1320 Braddock Place, Room 334, Alexandria, VA 22314; or fax: (833) 256-1665

or (202) 690-7442; or mail: FNSCIVILRIGHTSCOMPLAINTS@usda.gov
This institution is an equal opportunity provider.

Este aviso se refiere a la información importante acerca de sus beneficios, los plazos cortos para pedir una Audiencia y la manera de seguir recibiendo beneficios si usted está en desacuerdo con nuestra decisión. Llame de inmediato al DES al 1 (855) 432-7587 y DES le leerán este aviso a usted en español.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

HEARING REQUEST

See page 2 for your appeal rights and information on how to file an appeal

CLIENT INFORMATION

Name *(Last, First, M.I.)*: _____

HEAplus Application ID: _____ AZTECS Case Number: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Phone Number *(Include Area Code.)*: _____

I WANT AN APPEAL FOR THE FOLLOWING PROGRAMS: (CHECK BOX)

☐ Cash Assistance ☐ Nutrition Assistance ☐ Medical Assistance ☐ Tuberculosis Control

☐ Nutrition Assistance Overpayment Compromise

I WANT TO APPEAL BECAUSE I DO NOT AGREE WITH: (CHECK BOX)

☐ End of Benefits ☐ Amount of Benefits ☐ Denial of Application ☐ Overpayment

☐ Other *(Explain)*: _____

Reason(s) why I don't agree with your decision:

Date of the notice I do not agree with: _____

I want my hearing by: ☐ Telephone ☐ In person at *(Select a location below)*:

☐ Phoenix

☐ Tucson

NOTE: When an option is not selected, the hearing will be held by telephone.

I need an interpreter: ☐ Yes ☐ No *(If Yes, what language?)* _____

I need an accommodation for a disability: ☐ Yes ☐ No *(If Yes, explain)* _____

CONTINUED BENEFITS

IMPORTANT: You may keep getting benefits if you file an appeal within 10 days of the date of the notice you are disagreeing with or the effective date of the decision on the notice, whichever is later. Check one of the following boxes below if the reason for your appeal is because your benefits are being decreased or stopped.

☐ I **DO** want to keep getting benefits during my appeal.

☐ I **DO NOT** want to keep getting benefits during my appeal.

CAUTION: If you ask to continue your benefits, you may have to pay back any Cash or Nutrition Assistance you received while waiting for a hearing.

You cannot keep getting benefits while you wait for a hearing if:

- Your application was denied
- Your benefits were stopped because the approval period ended
- The law changed
- You received the maximum benefits under the program

Name *(Print or Type)*: _____

Signature: _____ Date: _____

See page 2 for USDA/EOE/ADA disclosures

YOUR APPEAL RIGHTS

DES must send you a letter when a decision is made on your case. An appeal is a request for a hearing. A hearing is your chance to explain your case to a judge who will decide if DES made the right decision.

You have the right to:

- Appeal any decision we made that you do not agree with.
- Appeal a decision we do not make on time.
- Ask for a pre-hearing meeting with DES to discuss your case.
- Ask to review your DES case file by contacting an FAA office.
- Get a copy of the law, rule or policy that we used in your decision.
- Present testimony and evidence at the hearing to support your case.
- Bring a representative or lawyer to the hearing.

What happens when you file an appeal?

- We will send you a notice asking you to contact us for a pre-hearing meeting with DES. This meeting is to see if we may be able to fix the problem. This meeting is optional for you.
- If the problem cannot be fixed, the DES Office of Appeals will send you a notice telling you the date and time of your hearing.

What programs can you appeal?

Cash Assistance, Nutrition Assistance, Medical Assistance and Tuberculosis Control.

How do you file an appeal?

- Go online to your account at healthearizonaplus.gov
- Fill out this form and turn in the completed form by:
  Faxing:
  The Appeals processing Unit (APU) at 602-257-7058 or
  The Office of Appeals Phoenix: 602-257-7056 or Tucson: 602-257-7055
  You can mail the form to: Department of Economic Security – Appeals
  PO Box 19009, Phoenix, AZ 85005-9009
- Provide a written statement. This statement should include your name, case number or social security number, address, and phone number, the date of the letter you are appealing, and the reason you do not agree with the decision.
- To file a Verbal Appeal Request please call:

Appeals Processing Unit (APU):	Or	**Office of Appeals:**
Phone: 602-774-9279		Phone: 602-771-9019 or Toll Free 877-528-3330

What is the deadline to ask for an appeal?

You must ask for an appeal within:

- 30 days from the date on the decision notice for Cash Assistance and Tuberculosis Control.
- 35 days from the date on the decision notice for Medical Assistance.
- 90 days from the date on the decision notice for Nutrition Assistance.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

CHANGE REPORT

Use this form to report changes in your household circumstances. Complete and return this form with any proof of the changes by mail to: Department of Economic Security P.O. Box 19009, Phoenix, AZ 85005-9009, by fax to (602) 257-7031 when faxing from area codes 602, 480, or 623; or when faxing from any other area code use 1-844-680-9840, or call Customer Service at 1-855-HEA-PLUS (1-855-432-7587). You may also report changes online at www.Healthearizonaplus.gov or myfamilybenefits.azdes.gov. To add a program to your existing case you may apply online at www.Healthearizonaplus.gov, or call Customer Service at 1-855-HEA-PLUS (1-855-432-7587) for assistance.

Cash Assistance (CA) and Nutrition Assistance (NA) – All changes must be reported no later than the 10th calendar day of the month following the month the change occurs.

Medical Assistance (MA) – All changes must be reported within 10 calendar days from the day you know about the changes.

<table>
<tr>
<td>Simplified Reporting Households - CA participants must report the following:
Report changes when your household's income exceeds 36% of the Federal Poverty Level (FPL).</td>
<td rowspan="3">Standard Reporting Households - changes in the following must be reported:
• All income for everyone in the household (earned and unearned) (For NA, report only when change in income is more than $125 per month)
• Address, including any resulting changes in housing and utility costs
• Household members (persons moving in or out)
• Marital status
• School attendance (CA only)
• Dependent care expenses
• Resources</td>
</tr>
<tr>
<td>NA participants must report the following:
Report changes when your household's income exceeds 130% of the current FPL.</td>
</tr>
<tr>
<td>Simplified Reporting does not apply to MA</td>
</tr>
<tr>
<td colspan="2">The following apply to NA Simplified and NA Standard Reporting:
Lottery and gambling winnings of $4,250 or more in a single game
Able Bodied Adult Without Dependents – Must report when their work hours fall below 20 hours per week, averaged monthly</td>
</tr>
</table>

IDENTIFYING CASE INFORMATION

Case Name *(Last, First, M.I.)*: _____ Date of Change: _____

AZTECS Case No: _____ HEAplus Application ID: _____ Social Security No: _____

NEW ADDRESS CHANGES
(Attach Proof of New Rent, Mortgage Amounts, and New Utility Costs)

Home Address *(No., Street, City, State, ZIP Code)*:

_____

Mailing Address, If Different From Above *(P.O., Apt/Space#/No., Street, City, State, ZIP Code):*

_____

County You Live In: _____ Home or Message Phone No.: _____

Landlord's Name & Phone No: _____

Landlord's Address *(No., Street, City, State, ZIP Code)*: _____

New Rent or Mortgage Cost: _____

I pay for: ☐ Water ☐ Phone ☐ Electric ☐ Gas ☐ None ☐ Other _____

See page 4 for USDA/EOE/ADA disclosures

HOUSEHOLD MEMBER CHANGES
(Attach Proof of Income or Resources For New Members, Including Children and Newborns)

Report changes when: someone moves in or out of your home, a household member is in the hospital, you or a member of your household has a baby, the death of a household member, a change to a household member's marital status, a parent no longer has a disability, etc.

Full Name *(Last, First, M.I.)*	Relationship to You	Birth Date/ Date of Death	Soc. Sec. No. *(Optional if not applying)*	Add to Your	Is Person	Date Moved
				☐ CA ☐ NA ☐ MA	☐ Pregnant ☐ Disabled ☐ U.S. Citizen ☐ Student Receiving Money	In: Out:
				☐ CA ☐ NA ☐ MA	☐ Pregnant ☐ Disabled ☐ U.S. Citizen ☐ Student Receiving Money	In: Out:

INCOME CHANGES *(Attach Proof)*

Have there been changes in the income members of your household receive? Income changes from working at a permanent or temporary job, any odd jobs, self-employment, babysitting, tips, bonuses, in-kind income, unemployment benefits, veterans' benefits, disability, retirement/pensions, gifts, contributions, child/spouse/medical support, SSA, SSI, BIA Assistance, money from roomers or boarders, educational income, land lease, interest, housing assistance or utility allowance, winnings *(including substantial lottery or gambling)*, etc.

Name of Person Receiving Income	Source *(If Earned, List Name of Employer and Phone Number)*	Amount *(Before Deductions)*	How Often is it Received?	Date of Change

FEDERAL TAX FILING CHANGES

Does anyone plan to file Federal Income Taxes? ☐ Yes ☐ No

If yes, who? _____

Are you planning to claim any dependents on your own tax return? ☐ Yes ☐ No

If yes, list names of dependents: _____

Will you be claimed as dependent on someone else's tax return? ☐ Yes ☐ No

If yes, name of tax filer claiming this person: _____

FILING STATUS: ☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return
☐ Married-Filing Joint Return *(Spouse's Name)*: _____

CHANGES IN SCHOOL ATTENDANCE *(Attach Proof)*

For CA: Must report school attendance for children 6 to 15 years old. **For NA:** you may report changes in student status.

Name of Person *(Last, First, M.I.)*	Name of School and Phone No.	Type of Change	Graduation Date – High School	Attending College
		☐ Start ☐ Stop		☐ Full Time ☐ Part Time
		☐ Start ☐ Stop		☐ Full Time ☐ Part Time

RESOURCE CHANGES (*Attach Proof*)

Did the total of your household's cash on hand, money in checking account and/or Savings account, stocks, bonds, etc. reach or exceed the resource limit for the benefits your household receives. Nutrition Assistance = $2,750, or Nutrition Assistance households that include members who are 60 years or older or have a disability = $4,250, or Cash Assistance = $2,000.

Name of Person Receiving	Type of Resource	Amount	Date of Change

EXPENSE CHANGES (*Attach Proof*)

Did any of your household's expenses change such as monthly dependent care expenses, rent, mortgage, utilities, etc. For Nutrition Assistance Households – If you pay court ordered child support, report changes of $50 or more. If you are 60 years or older or have a disability and have out of pocket medical expenses of $35.01 or more.

Name of Person with the Expense	Type of Expense	Amount	Date of Change

Will these changes continue next month? ☐ **Yes** ☐ **No**

If No, please explain: _____

IMPORTANT INFORMATION, PLEASE READ

If you purposely hold back information about changes in your household or give false information, you will owe the Arizona Department of Economic Security the value of any extra benefits you should not have received. You may be subject to penalties and possible criminal prosecution under state and federal law.

- **FOR NUTRITION ASSISTANCE. If you or any member of your family are found guilty of an intentional program violation (IPV), you will be disqualified for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense and may be subject to further prosecution under other state and federal laws. You or that person may also be fined up to $250,000, imprisoned up to 20 years, or both; and barred by a court from the Nutrition Assistance program for an extra 18 months.**
- **FOR CASH ASSISTANCE. If you or any member of your family are found guilty of an intentional program violation (IPV), you will be disqualified for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense and may be subject to further prosecution under other state and federal laws.**
- **FOR MEDICAL ASSISTANCE. You must not knowingly withhold or give false information with the intent to receive or continue to receive Medical Assistance. If the information you provide is incorrect, Medical Assistance may be denied or stopped. If you and/or your representative are found guilty of knowingly giving false information, you and your representative will be subject to criminal prosecution, which could result in fines, imprisonment, and other possible penalties under state or federal law. You may also be required to repay AHCCCS the amount of benefits paid during the period of ineligibility.**

Information provided on this form may increase, decrease, suspend, or stop your Nutrition Assistance, Cash Assistance, or Medical Assistance. A separate notice will be sent.

PLEASE SIGN AND DATE THIS FORM BEFORE RETURNING

Signature: _____ Date: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.