

# Family Report of Changes



Participant families with a [RENTCafé account](#), please use the Report a Change Tile to complete reports.

1. Please use this form to report:
  - a) New persons you wish to add or remove from your household.
  - b) Changes to your household's monthly income.
  - c) Changes to your monthly, out-of-pocket expenses for medical or disability-related expenses or child care for children under the age of 13 if you are a Traditional family (see below).
2. All changes reported by a family must have supporting documents attached. AHFC may require the family to attend an office appointment to complete these actions.
  - a) A New Household Member must:
    - Meet AHFC screening criteria before moving into the unit
    - Attach verification of his/her social security number
    - Attach verification of his/her date of birth (for persons under 18 years of age)
    - Attach a picture verification of an adult's identity (driver's license, passport, state identification, etc.)
    - Attach verification of income she/he is bringing to the household
  - b) A family must provide verification when a household member leaves
3. Please do not send AHFC any personal or confidential information describing a medical or health condition. AHFC collects just the costs or the medical/health expense supporting information.
4. Please do not use this form to request an exception to the requirement to pay AHFC's minimum rent. Please submit the Minimum Rent Exemption Request.

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## Family Program Types

### Moving to Work

- Classic
- Step
- Set Aside (ECHP, FYI, VASH)
- Set Aside Disabled (MHP, NED, MS)

You pay 28.5 percent of your monthly income as rent or you are paying an increasing amount of your monthly income each year toward rent.

Please remember that reported decreases in your monthly income may not result in a change to your rent.

Please do not use this form to:

- a) Report a change in income or household composition that you believe qualifies you

for AHFC's Bridge Process. Please submit the Bridge Application.

- b) Request that AHFC deduct your medical or disability out-of-pocket expenses from your annual income. If you are a person with a disability, please submit a Reasonable Accommodation Request.

### Traditional

These programs include HOP S8N Multifamily, and TBRA. You pay 30 percent of your adjusted monthly income as rent. You receive deductions for dependents, being an elderly or disabled household, and are eligible for out-of-pocket child care and medical expenses.



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You may request assistance with this document from AHFC.

## Head of Household

|                    |   |
|--------------------|---|
| Legal Name         | Last 4 Digits of Social Security Number |
| Mailing Address    | Telephone                               |
| City, ST, Zip Code |   |
| Email Address      |   |

## Family Composition (Please complete the table below.)

- I want to **add** an individual to my household.
- I want to **remove** an individual from my household.

| Last Name | First Name | MI | Gender | Birth Date | Date Left (Leaving) |
|-----------|------------|----|--------|------------|---------------------|
|           |            |    |        |            |                     |
|           |            |    |        |            |                     |
|           |            |    |        |            |                     |

## Family Income

My household now (or will) receives this income and wants to **add** it.

| Family Member Name | Income Description (Employer Name) | Starting When? | Monthly Amt. (\$) |
|--------------------|------------------------------------|----------------|-------------------|
|                    |                                    |                |                   |
|                    |                                    |                |                   |
|                    |                                    |                |                   |

If you are reporting a new job, please provide the following information.

|                  |           |
|------------------|-----------|
| Employer Name    | Telephone |
| Employer Address | Fax       |



My household no longer receives this income and wants to **remove** it.

| Family Member Name | Income Type | Description (Employer Name) | Ending When? |
|--------------------|-------------|-----------------------------|--------------|
|                    |             |                             |              |
|                    |             |                             |              |
|                    |             |                             |              |

**Allowances** (for Traditional families only, see Definition on page 1)

**1**  Yes  No Do you or does any adult living with you pay child care for a child (under 13) in your household so the adult can work, look for work, or go to school?

| Minor Name | Child Care Provider | Address | Monthly Amt. (\$) |
|------------|---------------------|---------|-------------------|
|            |                     |         |                   |
|            |                     |         |                   |
|            |                     |         |                   |

**2**  Yes  No If you are 62 years of age or older or a person with disabilities, do you have any changes in your medical expenses? Please complete the Medical/Disability Expense List.

**Personal Certification and Notice**

**Warning:** Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

I hereby certify under penalty of perjury under the laws of the United States of America and the State of Alaska that all of the information contained in this document is true and complete. I understand that making false statements on this document is a crime under state and federal law, which may result in termination from the program and criminal prosecution.

|   |              |      |
|---|--------------|------|
|   |              |      |
| Head, Spouse, or Co-Head of Household Signature | Printed Name | Date |

If a translator or translation service, AHFC staff, or other assistance was used to prepare this form, please list below.

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