

Housing Specialist _____

PERSONAL DECLARATION

THIS FORM MUST BE COMPLETED **IN INK AND IN YOUR OWN HANDWRITING**. YOU MUST USE THE CORRECT LEGAL NAME FOR EACH MEMBER OF YOUR HOUSEHOLD. ALL ADULT MEMBERS OF THE HOUSEHOLD MUST SIGN BELOW CERTIFYING THE INFORMATION. PLEASE READ EACH QUESTION CAREFULLY.

Head of Household: _____	Home Phone: _____
Street Address: _____	Work Phone: _____
City, State Zip code _____	Cell: _____
Mailing Address: _____	Pager: _____
(If different from above) _____	Other: _____

In case of an emergency, list the name & phone number of persons a message can be left with: _____

I. HOUSEHOLD MEMBERS: (All household members must provide proof of US Citizenship)

ADULTS - Everyone 18 or over (name as it appears on SS card)	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER (Verification of SS number must be provided)
1		SELF	
2			
3			
4			

CHILDREN - Everyone 0-17 (name as it appears on SS card)	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER (Verification of SS number must be provided)
1			
2			
3			
4			
5			
6			
7			

II. GENERAL INFORMATION:

Yes No Have you or any other household member been evicted from or owe money to another Public Housing Authority in connection with Section 8 or Public Housing?

Yes No Have you or any other household member ever been convicted as a sex offender or of manufacturing methamphetamines?

Provide a copy of your current lease, or provide the beginning and ending dates of your current lease here:
 Begin Date: _____ End Date: _____

Report ALL changes in income and household composition, in writing, within TEN days.
If you do not report all income, you must repay. It's the law!

III. HOUSEHOLD INCOME and ASSETS:

If Yes to any question below, you must provide documentation / proof to the PHA,
Documentation / proof must be less than 60 days old

Yes No Does any family member receive any income?

EXAMPLES: Employment/Wages/Earnings (A job), Unemployment, Workman's Compensation, Social Security (SS), Supplemental Security Income (SSI), Disability Income (other than SS or SSI), Alimony, Retirement, Pension, etc.

(If you receive SS / SSI you can contact SSA at 1-800-772-1213 or www.SSA.gov for a benefit statement)

WHO GETS IT	FROM WHOM / ADDRESS	HOURLY WAGE	HOURS PER WEEK	HOW OFTEN PAID	GROSS AMOUNT
1					
2					
3					
4					

Yes No Does any family member receive Child Support (Court ordered or Voluntary)? If voluntary, see next question. **Court ordered:** Support Enforcement Services ID# _____ PIN# _____

Yes No Does anyone pay any family bills or expenses, give you money or help out in any way? If Yes, You must provide a **NOTARIZED** statement from the provider with name, address, phone number, how often and how much.

- Yes No Does the family receive AFDC, FITAP, KINSHIP Care, TANF Grant or any other welfare grants?
- Yes No Is the family being sanctioned by the welfare office?
- Yes No Is any family member involved in an education or work program through the Office of Family Support?
- Yes No Does the family receive Food Stamps?
- Yes No Does any family member, 18 or older, attend school? (High School, College, Technical School, etc.)
- Yes No Is any family member involved in any Work Study or Job Training Program?
- Yes No Does any family member receive Financial aid (PELL Grant, SEOG, etc)?
- Yes No Has any family member sold or purchased any real estate in the last 12 months?
- Yes No Does the household have total assets of \$5000 or more? *Examples:* Bank Accounts, CD's, Life or Burial Insurance, Stocks, Bonds, Trusts, Royalties, Investments, Real Estate, Boat, Motor or Mobile Home?

IV. EXPENSES:

Yes No **Medical Expenses** – exceeding 3% of annual income may be claimed for the entire household if the head or spouse is elderly, handicapped or disabled. Only un-reimbursed costs may be claimed. These include, but are not limited to, Medicare / health insurance premiums, prescription drug costs, or other items as are listed on IRS publication #502. You must supply proof of expense and payments made, printouts from pharmacies or other items to prove the medical expenses for the last 12 months. Medical costs are anticipated for the upcoming 12-month period based on the previous 12-months medical expenses.

Yes No Medicare Prescription Drug Plan: If Yes, Name: _____

Yes No Are any of these medical expenses reimbursed to the household? If Yes, provide documentation.

Yes No Are any household children in childcare? If the provider is an INDIVIDUAL: you must provide a **NOTARIZED** statement from the provider with name, address, phone number, how often and how much is paid by the family. If the provider is a LICENSED DAY CARE: you must provide a statement from the provider with name, address, phone number, how often and how much is paid by the family. *Any reimbursed childcare expenses must be reported!*

Yes No Does the family receive childcare assistance, If Yes, provide documentation to the PHA.

I understand that any misrepresentation of information or failure to disclose information requested on this declaration may disqualify me from consideration for admission or participation, and may be grounds for denial or termination of assistance. I also understand that ANY CHANGES in the household income, assets or composition must be reported to the Housing Authority in WRITING IMMEDIATELY.

I do hereby certify that the above information is true, accurate and complete to the best of my knowledge.

SIGNATURE OF HEAD OF HOUSEHOLD

DATE

SIGNATURE OF OTHER ADULT

DATE

SIGNATURE OF OTHER ADULT

DATE

SIGNATURE OF OTHER ADULT

DATE