Town of Johnston Housing Authority

8 Forand Circle Johnston, Rhode Island 02919 (401) 231-2007



Application For Public Housing

_____ Tel. No.____

	Address			City			State Zip		
	3. How long have	you lived at you	ur present addr	ess?					
j	4. List your forme	er address							
	5. Marital Status:	Single Marri	ed 🗆						
	6. If Divorced or S	Separated: Name	of Former Spo	use					
	7. Maiden Name	(if different fron	n above)						
В.	Are you a vete	ran? YES 🗆 🛚	NO □ Inductio	n Date		Discl	narge Date		
	2. Are you receive	ing veteran's ber	nefits as the fam	nily of a servicer	nan?	YES 🗆 N	0 🗆		
	3. Are you a disa	bled veteran?	YES NO	Service Serial N	0				
C.	List the names and	d phone numbers	s of two friends	or relatives tha	t we	can contact	if we are unable	to reach you.	
	Name					Tel. No			
	Name					Tel. No	_ Tel. No		
D.	Have you been co	nvicted of a felo	ny within the la	est five years?	YES [□ NO □ if	so, when and sta	ate the	
	conviction:		(A)			g		d	
E.	List all persons inc	luding yourself,	who will live in	this rental unit	while	e you are on	this program, lis	t head of the	
	household first as		and then each	family member.	Use	your proper	Family Member	Number (No.)	
_	in the following senily Member No.								
	Full N		Place of Birth	Relationship to Family Head	Sex	Date of Birth	Social Security No.	Occupation	
1				HEAD					
2					_				
3			-		-				
4			-	-	-				
5	-				-				
6	1					1			
7					-				
7 8									
7 8 9							-		

F. EMPLOYMENT

List all full and/or part-time employment anticipated within the next 12 months for all Household members (other than minor, dependent- children under the age of 18)

• If self employed use net income from business. (Depreciation of property is allowed, and should be based on the straight line method used for tax purposes.)

Family Member No./Name	Name & Address of Employer	Gross Earnings	Wk./Mo./Yr.
1		\$	_ per
2		\$	_ per
3	· ‡	\$	_ per
4		\$	_ per
5		\$	_ per

G. OTHER SOURCES OF INCOME

List ALL income anticipated within the next 12 months by each family member.

Family Member No.	1.	2.	3.	4.	5.
,	\$	\$	\$	\$	\$
1. Welfare					
2. Social Security					
3. SSI					
4. Pension					
5. VA Benefits					
6. Unemployment					
7. Alimony					
8. Child Support					
9. Excess Tax Credit					
10. Other					

H. ASSET INFORMATION Name of Ban	k	Amount	Ac	count No.
Checking:				
Savings:				
Savings Certificates:	Annua	I Interest Received:	Valu	e:
itocks and Bonds:	Annua	al Dividend Received:	Valu	e:
Property Owned, Address:			Valu	ıe:
Other, Explain:	Incon	ne Rec'd Monthly:	Valu	e:
Assets disposed of within the last 2 y	ears for less than Mark	et Value, please explair	n:	
	11			
. MEDICAL EXPENSES Elderly families only (Age 62 ha	ndicapped or disabled)			
Do you pay any portion of the cost of		spitalization Coverage	(i.e. Blue Cross, M	ledicare, Etc.)
/ES □ NO □ if yes, how much? \$_				
ist separately all medical expenses		ot covered by Medical	Insurance (i.e. pr	escriptions, No
prescription drugs, etc.)				
List handicapped assistance expenses	that are anticipated du	_		
List handicapped assistance expenses iliary apparatus for Handicapped or ing the Handicapped or Disabled meside source. Family Member No. Person/Agency	that are anticipated du Disabled Family membe	ers that are necessary to provided that the expen	o enable a Family	member (inclu
List handicapped assistance expenses liary apparatus for Handicapped or ng the Handicapped or Disabled meside source. Family Person/Agency Person/Agenc	s that are anticipated du Disabled Family membe ember) to be employed,	ers that are necessary to provided that the expen	o enable a Family nses are not reimb	member (inclu oursed by an ou
List handicapped assistance expenses liary apparatus for Handicapped or ng the Handicapped or Disabled meside source. Family Person/Agency Person/Agenc	s that are anticipated du Disabled Family membe ember) to be employed,	ers that are necessary to provided that the expen	o enable a Family nses are not reimb	member (inclu oursed by an ou
List handicapped assistance expenses liary apparatus for Handicapped or ng the Handicapped or Disabled medide source. Family Person/Agency	that are anticipated du Disabled Family member mber) to be employed, Addr	ers that are necessary to provided that the expensess	Description Description	Cost Week
List handicapped assistance expenses liary apparatus for Handicapped or ng the Handicapped or Disabled metide source. Family Member No. Person/Agency f any special apparatus is needed for family member to work, list items here.	Addr or handicapped/disabled ere. Description:	ers that are necessary to provided that the expensess	Description Description	Cost Week
List handicapped assistance expenses liary apparatus for Handicapped or ng the Handicapped or Disabled medide source. Family Person/Agency f any special apparatus is needed for family member to work, list items here. Does any member of your household	Address of handicapped/disabled ere. Description:	family members to wo	Description Description	Cost Week
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L.	PROGRAM INFORMATION					
1. Have you been displaced by a fire, a natural disaster or public action? YES \square NO \square						
	if yes, explain					
2.	Is your present housing condemned? YES \(\simeg \) NO \(\simeg \)					
3.	Is your present housing substandard? YES \(\square\) NO \(\square\)					
	Present monthly rent \$ No. of Bedrooms					
	Does the rent and utilities represent more than 50% of your monthly income? YES \square NO \square					
	Utilities: please list all utilities paid by you					
	a. Heat \$per month					
	b. Electric \$per month					
	c. Other \$per month					
4.	Have you ever applied for Public Housing or participated in a Rental Assistance Program? YES \(\square\) NO \(\square\)					
	if yes,where and explain					
5.	Are you living in or have you ever lived in Public Housing? YES \(\square\) NO \(\square\)					
	if yes, where					
6.	Do you owe any back rent to the Johnston Housing Authority or to any former or current landlord? YES \square NO \square					
	f yes, explain					
7.	. Have you ever been evicted or violated your lease while participating in a Public Housing Program? YES \Box NO \Box					
8.	. What is the name, address and telephone number of your current landlord?					
9.	. What is the name, address and telephone number of your former landlord?					
Ple	ase feel free to use additional paper if necessary when answering any of the above questions.					
M. RACIAL DATA: The following information is required for statistical purposes so the department of HUD may det degree to which its programs are utilized by minority families.						
	WHITE □ BLACK □ AMERICAN INDIAN or ALASKAN NATIVE □ ASIAN or PACIFIC ISLANDER □					
	HISPANIC NON-HISPANIC					
WA	ARNING: false statements or information on this application are grounds to terminate your application for housing assistance, and are punishable under Federal and State Law.					
Ap	plicant's Signature: Date:					
	to the self-self-self-self-self-self-self-self-					

Important: If you move, you are required to notify the Authority in writing or you cannot be considered for assistance.

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. You may update, remove, or change the information you provide on this form at any time. You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:					
Mailing Address:					
Telephone No: Cell Phone No:					
Name of Additional Contact Person or Organization:					
Address:					
Telephone No: Cell Phone No:					
E-Mail Address (if applicable):					
Relationship to Applicant:					
Reason for Contact: (Check all that apply)					
Emergency Unable to contact you Change in lease terms Termination of rental assistance Eviction from unit Late payment of rent	es s				
Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.					
Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.					
Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.					
Check this box if you choose not to provide the contact information.					

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Signature of Applicant

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.

Form HUD- 92006 (05/09)

Date