SMOKE FREE

Town of Johnston Housing Authority
8 Forand Circle
Johnston, Rhode Island 02919
(401) 231-2007

Application For Public Housing

A. 1. Name _____ Tel. No._____

2. Address _____ City_____ State_____ Zip_____

3. How long have you lived at your present address? _____

4. List your former address _____

5. Marital Status: Single ☐ Married ☐

6. If Divorced or Separated: Name of Former Spouse _____

7. Maiden Name (if different from above)_____

B. 1. Are you a veteran? YES ☐ NO ☐ Induction Date_____ Discharge Date_____

2. Are you receiving veteran's benefits as the family of a serviceman? YES ☐ NO ☐

3. Are you a disabled veteran? YES ☐ NO ☐ Service Serial No._____

C. List the names and phone numbers of two friends or relatives that we can contact if we are unable to reach you.

Name _____ Tel. No._____

Name _____ Tel. No._____

D. Have you been convicted of a felony within the last five years? YES ☐ NO ☐ if so, when and state the conviction: _____

E. List all persons including yourself, who will live in this rental unit while you are on this program, list head of the household first as Number one (1) and then each family member. Use your proper Family Member Number (No.) in the following sections.

Family Member No.	Full Name	Place of Birth	Relationship to Family Head	Sex	Date of Birth	Social Security No.	Occupation
1			HEAD				
2							
3							
4							
5							
6							
7							
8							
9							
10							

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 Bank	Amount	Account No.
Checking:			
Savings:			

Savings Certificates:_____ Annual Interest Received:_____ Value:_____

Stocks and Bonds:_____ Annual Dividend Received:_____ Value:_____

Property Owned, Address:_____ Value:_____

Other, Explain:_____ Income Rec'd Monthly:_____ Value:_____

Assets disposed of within the last 2 years for less than Market Value, please explain:

_____

_____

I. MEDICAL EXPENSES

Elderly families only (Age 62 handicapped or disabled)

Do you pay any portion of the cost of Medical/Insurance/Hospitalization Coverage (i.e. Blue Cross, Medicare, Etc.)

YES ☐ NO ☐ if yes, how much? $_____

List separately all medical expenses and amounts that are not covered by Medical Insurance (i.e. prescriptions, Non-prescription drugs, etc.)

_____

_____

J. HANDICAPPED ASSISTANCE EXPENSES

List handicapped assistance expenses that are anticipated during the next 12 months. Include attendant care and auxiliary apparatus for Handicapped or Disabled Family members that are necessary to enable a Family member (including the Handicapped or Disabled member) to be employed, provided that the expenses are not reimbursed by an outside source.

Family Member No.	Person/Agency	Address	Description	Cost Weekly

If any special apparatus is needed for handicapped/disabled family members to work, or necessary to enable another family member to work, list items here. Description:_____ Cost:_____

Does any member of your household use a wheelchair? YES ☐ NO ☐

Does any member require special housing facilities? YES ☐ NO ☐

Explain:_____

_____

K. CHILD CARE EXPENSES

Fill in the amounts you anticipate to pay in the next 12 months for children under the age of 13•. **Complete this section only if:** The purpose of the child care is to allow a family member to be gainfully employed or further his/her education.

Do you pay for child cares? YES ☐ NO ☐ if yes, list Child Care provider. Cost per week $_____

Name_____ Address_____ Tel. No._____

L. PROGRAM INFORMATION

1. Have you been displaced by a fire, a natural disaster or public action? YES ☐ NO ☐

   if yes, explain_____

2. Is your present housing condemned? YES ☐ NO ☐

3. Is your present housing substandard? YES ☐ NO ☐

   Present monthly rent $_____ No. of Bedrooms_____

   Does the rent and utilities represent more than 50% of your monthly income? YES ☐ NO ☐

   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 ☐ NO ☐

   if yes,where and explain_____

5. Are you living in or have you ever lived in Public Housing? YES ☐ NO ☐

   if yes, where_____

6. Do you owe any back rent to the Johnston Housing Authority or to any former or current landlord? YES ☐ NO ☐

   if yes, explain_____

7. Have you ever been evicted or violated your lease while participating in a Public Housing Program? YES ☐ NO ☐

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?

   _____

Please 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 determine the degree to which its programs are utilized by minority families.

WHITE ☐ BLACK ☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ ASIAN or PACIFIC ISLANDER ☐

HISPANIC ☐ NON-HISPANIC ☐

WARNING: false statements or information on this application are grounds to terminate your application for housing assistance, and are punishable under Federal and State Law.

Applicant's Signature:_____ Date:_____

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

OMB Control # 2502-0581
Exp. (02/28/2019)

Optional and Supplemental 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:	
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason to Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

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.

Signature of Applicant	**Date**