**HCV APPLICATION FOR CONTINUED ASSISTANCE**

***Please complete and submit supporting documents, as requested.*** ***Print clearly. Answer ALL questions with either Yes, No, or None. Do not use N/A in any of the answers. Don’t forget your glasses! 😊***

1. **FAMILY COMPOSITION:** Head of household’s name is to be Occupant #1. Then list the names of all other persons who reside in your apartment. *I understand that failing to report everyone living in the apartment is considered “Theft by Deception” and can result in your housing assistance being terminated, being fined up to $10,000 or imprisoned up to five years.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Occupant # | Name(s) of ALL persons who reside in apt. (First name, middle initial, last name.) | Relation to Head (HOH) | Veteran Y/N | Sex | Age | Full Time Student: Yes/No If Yes: **School Name** (Age 17+ **Graduation Date**) |
| **1** |  | HOH |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |

1. **Name(s) and address(es) of ALL absent parents to minor children listed above.** If needed, attach a separate sheet of paper.

Absent Parent **1** Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address: Date of last contact: \_\_\_\_\_\_\_

Absent Parent **2** Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address: Date of last contact: \_\_\_\_\_\_\_

Absent Parent **3** Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address: Date of last contact: \_\_\_\_\_\_\_ Absent Parent **4** Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address: Date of last contact: \_\_\_\_\_\_\_

1. **Is anyone listed above ABSENT from the unit? \_\_\_ Yes \_\_\_ No You are required to notify the AHA when anyone is**

**absent (hospital, rehab, nursing home, moved, school, etc.) from the unit immediately. Why did they leave? .**

1. **Is a change in your family composition (size) anticipated in the next 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No (Birth of a child, adult child move-out, etc.)** If yes, explain here:
2. **Have the police responded to your residence for any reason, in the past year? \_\_\_ Yes \_\_\_No**  Explain below.

**Has anyone listed above: been arrested? \_\_\_ Yes \_\_\_No** Or **subject to a lifetime registration requirement under a state sex offender registration program? \_\_\_ Yes \_\_\_No** OrWhich state(s):

If yes explain here (add paper if needed):

1. **My PRIMARY LANGUAGE is:** You have the right to an interpreter free of charge, contact the office.
2. **YOUR CURRENT address:**(include apt #, city, state, zip)**:**
3. **Your MAILING address** (if different):

Telephone #, (Cell): (Other):

E-Mail address:

1. **LANDLORD NAME**: Phone #: Your portion of rent: $

Check one:For the time being, I plan to remain in the apartment I currently receive rental assistance for.

I wish to move. I understand that I must give written notice to my landlord at least 30 days before I move, and I MUST give this notice to my landlord on or before the first of any given month. I understand that I must give a copy of my notice to the AHA. \*\*LL Questionnaire\*\*

Reason for move:

1. **EMERGENCY CONTACT PERSON;** when we cannot reach you regarding your rental assistance:

Name: Relationship:

Address: Telephone #:

1. **UTILITIES:** What are the balances on your most recent: electric bill $ gas bill $

***\* submit all pages of your electric and gas bills.***

1. **CHILD CARE:** Any household members, listed in #1 in childcare? YES **\_\_\_** NO**\_\_\_**

Name: Amount **you pay**: $ wkly/mthly

Address: Do you have a **voucher**?YES **\_\_\_** NO**\_\_\_ Submit copy**

1. **ASSETS:** Our household’s **total assets** are (circle one) **UNDER** (see attached) or **OVER $5,000** verifications needed.
2. **CONTRIBUTIONS:** Is anyone helping you pay your bills (phone, cable, gas, car insurance, etc.)? **\_\_** Yes  **\_\_\_**No

Is anyone gifting you (cash, diapers, cigarettes, clothing, household supplies, etc.)? **\_\_\_** Yes **\_\_\_**No  **Budget Checklist**

1. **INCOME:** **List ALL income of ALL people:** **(INCLUDING CHILDREN)** Income includes, but is not limited to: Social Security benefits, all types of pensions, employment, unemployment compensations, Workman’s Compensation, all forms of public assistance (TAFDC, etc.), child support, alimony, disability, death benefits, Veteran’s Administration, financial aid from children, contributions (cash or products) from friends or relatives, interest and dividends, and any other form of income, including rental income from property and income from owning your own business.  **Budget Checklist**

***\*Required:*** ***pay stubs or letter from employer on letterhead with details, DOR summary page or notarized letter, or benefit letter, etc.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Family Member Name** | **Income Source** | **Amount $** | **Frequency – Circle One** |
| **Adult #1**  Head of Household | 1. | Social Security |  | **Week / Month / Year** |
| SSDI or SSI |  | **Week / Month / Year** |
| Massachusetts SSP |  | **Week / Month / Year** |
| Wages (2-6 consecutive paystub needed) |  | **Week / Month / Year** |
| **Adult #2**  Spouse . or Co-Head | 2. | Social Security |  | **Week / Month / Year** |
| SSDI or SSI |  | **Week / Month / Year** |
| Massachusetts SSP |  | **Week / Month / Year** |
| Wages (2-6 consecutive paystub needed) |  | **Week / Month / Year** |
| **Adult #3**  Other | 3. | Social Security |  | **Week / Month / Year** |
| SSDI or SSI |  | **Week / Month / Year** |
| Massachusetts SSP |  | **Week / Month / Year** |
| Wages (2-6 consecutive paystub needed) |  | **Week / Month / Year** |
|  | 4. | Pension |  | **Week / Month / Year** |
|  | 5. | Child Support |  | **Week / Month / Year** |
|  | 6. | Child Support |  | **Week / Month / Year** |
|  | 7. | Wages (2-6 consecutive paystub needed) |  | **Week / Month / Year** |
|  | 8. | Wages (2-6 consecutive paystub needed) |  | **Week / Month / Year** |
|  | 9. | Unemployment |  | **Week / Month / Year** |
|  | 10. | Unemployment |  | **Week / Month / Year** |
|  | 11. |  |  | **Week / Month / Year** |
|  | 12. |  |  | **Week / Month / Year** |
|  | 13. |  |  | **Week / Month / Year** |
|  | 14.  ***Need more lines? Add a sheet of paper.*** | **Contributions** from someone outside of your household: i.e., cash, diapers, formula, cell phone, help paying bills, etc. |  | **Week / Month / Year** |

1. **TAX RETURNS:** Did you file a tax return last year? **\_\_\_** Yes  **\_\_\_**No Can you or anyone in your household be claimed on another person’s return (parent, child, etc.)? **\_\_\_** Yes **\_\_\_** No  ***Please submit a copy of your tax return!***
2. **MEDICAL EXPENSES: (elderly/handicap/disabled only):** List any ongoing medical expenses (doctor, dental, pharmacy, equipment rental, etc.). ***Ask the drug store for an annual statement and bring it with you.*** Use additional page if necessary:

|  |  |  |
| --- | --- | --- |
| Occupant | Name and Address of Doctor/Pharmacy/or Mileage log etc. | Amt. Paid (weekly/monthly/yearly) |
|  |  |  |
|  |  |  |
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**Head of Household Initials**

**I/We will report, in writing, any changes in the above information within 10 days of such change.**

**I/We understand that failure to provide information as required may result in termination of my voucher.**

**I/We understand that failing to pay utilities is considered a “failure to act” and grounds for termination.**

***By signing below, I/we certify, under the pains and penalties of perjury, that the information provided on both sides of this form and documents submitted in support, are true and accurate to the best of my/our knowledge. False, misleading, or incomplete information may result in the termination of your Housing Choice Voucher Program (Section 8) assistance.***

WARNING: Section 1001 of the Title 18 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any departments of the United States Government. A family that knowingly submits false information is subject to a civil penalty, plus damages, under the False Claims Act (31 U.S.C. 3729)

**Head of Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**Spouse / Co-Head: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other adult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other adult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other adult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Athol Housing Authority Policy: In general, **decreases** to the family’s share of the rent will be effective on the first day of the month following the month in which the change was reported and all required documentation was submitted; an **increase** in the family’s share of the rent will be effective on the first of the month following a 30 days’ notice in advance. Regardless of whether it is an annual or interim recertification: If a family causes a delay in processing or fails to report a change within the required time frames or fails to provide all required information within the required time frames, the increase will be applied retroactively, to the date it would have been effective had the information been provided on a timely basis. The family will be responsible for any overpaid subsidy and may or may not be offered a repayment agreement.

What this means is: By causing a delay or “failing to act” you will not receive 30-day notice of a rent increase.

As a reminder: “Failing to act” is a violation of the program regulations and grounds for termination.

**As the representative for the Athol Housing Authority, I hereby certify, by my signature, that I have reviewed with the Head of Household all answers provided to ensure that these questions were fully understood and fully answered.**

**Signature of AHA Representative** **Date**