ROCHESTER Housing Authority

HOUSEHOLD INCOME & COMPOSITION FORM

Forward completed applications to:
Rochester Housing Authority
Leasing Operation's Department
675 West Main Street
Rochester NY 14611
(585) 697-6105 – phone

Instructions:

*The following information is required to re-certify your eligibility for housing assistance with RHA. Please **PRINT** clearly and complete all questions. **Do not leave any blanks**. If a question does not apply to your household, enter "NA" as a response. If you or any household member is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, contact our office. Submit this form with the required documentation described under each category.*

1. HOUSEHOLD INFORMATION:

HEAD OF HOUSEHOLD:

Social Security Number ___-___-____ Last Name _____ First Name _____

Street Address _____

City _____ State ____ Zip _____ DOB(mm-dd-yyyy) __-__-____ Sex M [ ] F [ ]

Phone #: (___) ___-____ Cell Phone #: (___) ___-____ Work #: (___) ___-____

E-Mail Address: _____

Auto Make	Model	Year	License Plate #	Driver's License #

What is your current marital status? [ ] Single [ ] Married [ ] Divorced

If there's a change, provide verification: ex: marriage license, separation agreement, divorce papers.

List all other HOUSEHOLD MEMBERS living at the above address. Provide a birth certificate and social security card for each NEW household member listed. Answer all questions for every listed member. If more space is needed attach extra sheets to the back.

	NAME	SOCIAL SECURITY NUMBER	SEX M/F	DATE OF BIRTH	AGE	RELATION TO HEAD OF HOUSE	LEAD LEVEL (see below)
1							
2							
3							
4							
5							
6							

You are **required** to immediately notify RHA if there is a child six years of age or under who is tested and diagnosed with an Environmental Intervention Blood Lead Level (EIBLL) so that RHA can assist in taking corrective action. Lead (paint) poisoning is considered to be in the EIBLL range when the level in whole blood is equal to or greater than 5 ug/dl or two consecutive tests are equal or greater than 5 ug/dl within 3-4 months of each other as revealed by the blood drawn medical testing (venal) puncture. Note: Finger pricks do not constitute blood drawn testing.

[ ] Yes [ ] No Does anyone in the household six years of age and under have a current EIBLL diagnosis? If yes, write the EIBLL level next to that person's name on the chart above.

[ ] Yes [ ] No Is any household member pregnant?

[ ] Yes [ ] No Are you or any member of your household subject to a lifetime state Sex Offender program in this or any state?

Verified _____
Staff Initial _____

RHA requires that all ABSENT PARENT(S) be identified for all children listed in the household.

Child's Name	Absent Parent's Name and Address	Is there a child support order?
1 _____	_____	Yes / No
2 _____	_____	Yes / No
3 _____	_____	Yes / No
4 _____	_____	Yes / No

2. WAGES:

[ ] Yes [ ] No Is anyone in the household EMPLOYED?

If yes, use the following chart to report income from WAGES (include formal and informal day care income or any self-employed income) Provide consecutive pay stubs representing 4 weeks of pay, and a copy of your current 1040 Federal Income Tax form. If you do not have a copy of your tax return, you may obtain a free tax transcript by calling 1-800-829-1040.

Household Member	Employer Name/Address/Zip Code	Regular Hourly Rate	# Hrs/ Week	Other Hourly Rate	# Hrs/ Week	# Weeks/ Year

3. PUBLIC ASSISTANCE:

[ ] Yes [ ] No Does anyone in the household receive Food stamps?
If yes, write the amount of Food Stamps received per Month $_____

[ ] Yes [ ] No Does anyone in the household receive TANF?
If yes, provide the PA Case # BA _____
PA Case Worker's Name_____ Phone ( )_____

[ ] Yes [ ] No Is this an NDG Grant?(A grant for a non-dependent)

From the PA budget sheet: # of people in the household _____ # of people on the Case _____
List all Household Members who are on your Public Assistance Grant:

1._____ 2._____

3._____ 4._____

5._____ 6._____

[ ] Yes [ ] No Does anyone in the household receive CHILD SUPPORT?
(If an agency or person(s) supports a child by providing money, food, clothing, diapers or any other product or service, list the dollar amount or estimated value of that product or service on the chart below and provide a written statement from the provider. If the child support is court ordered, list the county and provide a payment history which can be obtained by calling 1-888-208-4485 or accessing the website: www.newyorkchildsupport.com)

Household Member receiving support	Person/Agency name providing support	Amount	Write Weekly, Bi-Weekly or Monthly
		$	
		$	
		$	

[ ] Yes [ ] No Does anyone in the household have any OTHER SOURCE OF INCOME? If yes, list all other sources of income for all household members including children.
Other sources of income may be, but are not limited to: Social Security SSI, SSD, Veteran's Benefits, Pensions, Unemployment Benefits, Disability, Worker's Compensation, Alimony, regular monetary gifts from others for any household member, etc. Provide documentation for each source of income.

Household Member	Source of Income	Amount	Write Weekly, Bi-Weekly or Monthly
		$	
		$	
		$	

4. ASSETS:

[ ] Yes [ ] No Does anyone in the household, including children, have bank account(s) (checking, savings, Money Markets, CDs) and/or stocks, bonds, mutual funds, life insurance policies, IRAs, etc.? If yes, provide a current statement for each account listed below

Bank Name	Account Number	Type of Account	Current Balance	Interest Rate	Name on Account

[ ] Yes [ ] No Does anyone in the household own any real estate property? If yes, provide the following:
Property Address/Description: _____ Estimated Value $_____

[ ] Yes [ ] No Have you disposed of any assets for less than fair market value in the past 2 years?

List Disposed Asset(s) _____

5. EXPENSES AND DEDUCTIONS:

[ ] Yes [ ] No Is the head of household or spouse elderly or disabled?
If yes, the medical expenses of all family members may be counted. Provide paid receipts of all out-of-pocket medical expenses that are not covered by insurance. Include insurance premiums, co-pays and prescriptions not covered by Medicare. **NO INDIVIDUAL PRESCRIPTION RECEIPTS WILL BE ACCEPTED: ONLY COMPUTER PRINT-OUTS FROM THE PHARMACY.**

[ ] Yes [ ] No **Is any other household member disabled or handicapped?**

[ ] Yes [ ] No **Do you require a strobe alarm in your unit? (24CFR982.401 & NFPA 72)**

[ ] Yes [ ] No **Is any other household member under the age of 13?**

*If you answered yes to either question and you are working or attending school, the cost of caring for these family members **may be** deductible. Provide documentation (for example, receipts or DSS daycare notice of decision) for the cost of this care and complete the following:*

Name of Care Giver:	Address of Care Giver: Street City Zip Code

Paid by **Agency**: $_____ per week for summer (12 weeks) Paid by **Agency:** $_____per week during school yr.

Paid by **Family**: $_____ per week for summer (12 weeks) Paid by **Family:** $_____per week during school yr.

[ ] Yes [ ] No **Does anyone in the household 18 years of age and older, other than the head of house or spouse attend school full time? If yes, list name(s):**

Student's Name_____ School Attending _____

Student's Name_____ School Attending_____

*If that person is working, all but $480 of his earned income **may** be excluded. Provide documentation of full-time student status for each person listed along with a pay stub from each employer that includes the employer's name, address and zip code.*

6. CERTIFICATION: I certify that the household information provided to RHA on household information, wages, other income, EIBLLs, income, assets, expenses and deductions is accurate and complete to the best of my knowledge and belief. I understand that income information is subject to verification utilizing HUD's Enterprise Income Verification (EIV) system. I understand that giving false information or statements can be grounds for prosecution under federal and state laws. I also understand that giving false statements or information can be grounds for termination of housing assistance, subject to my right to a fair hearing.

RHA requires all adult household members (those who are 18 years of age or older) to sign this certification.

Head of House	Date	Other family members over age 18	Date
Spouse	Date	Other family members over age 18	Date
Other family members over age 18	Date	Other family members over age 18	Date
Other family members over age 18	Date	Other family members over age 18	Date

Declaration of Preparer (other than participant) is based on all information requested and provided by the participant.

PREPARER'S NAME:_____ Preparer'sSignature:_____

Relationship to Participant: