

Certification/Recertification Questionnaire

Cert/Recert Date _____

Name: _____

Unit: _____

Development: _____

City: _____

I. HOUSEHOLD COMPOSITION:

Member's Full Name	Relationship	Date of Birth	Social Security No.

II. INCOME/ASSETS:

A. Income

Yes No Amount

Do you receive or expect to receive:

Wages, salaries (includes overtime, tips, bonuses, self-employment)?

Does any member work for someone who pays them cash?

Regular pay for a member of the armed forces?

Welfare or disability benefits (MFIP, SSI, MSA)?

Child Support?

Alimony?

Social Security payments?

Pensions (PERA, Railroad, etc.)?

Retirement benefits

Veteran's Administration benefits?

Death benefits?

Unemployment benefits or severance pay?

Workman's compensation?

Annuities or life insurance dividends?

Insurance Policies?

Disability or Death Benefits?

Retirement Funds?

Regular cash contributions or gifts from individuals not living in the unit(includes rent, utilities, groceries, etc.)?

Have you received or expect to receive lump sum payments such as:

Yes No Amount

Inheritances

Lottery Winnings

Insurance Settlements (health, accident, Worker's Compensation, etc.)

Capital Gains

Social Security Benefits, Unemployment Compensation, etc.

Other (specify) _____

B. Assets

Yes

No

Amount

Have you disposed of any assets for less than Fair Market Value in the past two years?

If yes, please describe the asset(s) disposed of, date of disposition, fair market value and amount received. _____

Are any of the assets listed below held jointly with another person?

Which ones? _____

Do you have money held in:

Checking accounts?

Savings accounts?

Stocks?

Bonds?

Annuities?

Securities?

Trusts?

IRA/KEOGH?

Certificates of Deposit?

Money Market?

Safety Deposit Box?

Do you own a home, farm or other real estate?

If yes, are you in the process of selling it?

Do you receive rental income from a home, farm or other real estate?

Do you have any coin collections, antique cars, gems/jewelry, stamps, or any other items held as an investment (wedding rings and personal jewelry are not counted)?

III. MISCELLANEOUS:

A. Day Care

Yes

No

Amount

Do you have child care expenses for a child(ren) under age 13 because you work, are actively seeking employment or attending school? If yes, name and address of provider _____

\$_____ paid per month. Is any portion paid by another person or agency?

If yes, name and address of provider _____

Do you pay for a Care Attendant or any equipment for a handicapped member of the household necessary to permit that person or someone else in the household to work? If yes, name and address of provider _____

\$_____ paid per month. Is any portion paid by another person or agency?

If yes, name and address of provider _____

B. Additional Household Information

Yes

No

Are any household members temporarily absent?

Are any household members permanently absent?

Has the employment status for any household member changed?

IV. DEDUCTIONS:

Medical – Complete if you are at least 62 years old, handicapped or disabled.

	Yes	No	Amount
Do you have Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any other kind of medical insurance? Name & address of insurer: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you receive medical assistance? If yes, do you have a monthly spend-down?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you pay for prescription medication? Name & address of pharmacy _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any non-prescription (over-the-counter) medication that your doctor has requested you to use on a regular basis? (i.e., insulin, aspirin, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any outstanding medical bills on which you are paying? If yes, indicate the types of bills owed: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Owed to, name and address: _____			
Do you expect to have an extraordinary medical/dental expenses in the next 12 months ? If yes, list the amount and type of expense: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Name and facility where this can be verified: _____			
Doctor's name and address: _____			

Please bring receipts for your non-prescription medication.

VEHICLE INFORMATION:

Do you have a car? yes no

If yes, complete the following:

Make	Model	Year	Color	License Plate #

List all licensed drivers in the household

Name	Age	License #

EMERGENCY INFORMATION:

Name: _____	Relationship: _____
Name: _____	Phone: _____
Name: _____	Relationship: _____
Name: _____	Phone: _____

I/We certify that the information provided in the Certification/Recertification Questionnaire is true and complete to the best of my/our knowledge and belief. I/We understand that penalties under the Section 8 housing program's regulations may be imposed if I/we furnish false or incomplete information. Those penalties include, but are not limited to, loss of subsidy and/or tenancy. I/We further understand that changes in my/our income and/or family composition must be reported to management in accordance with the requirements of the Section 8 housing program.

_____ Head of Household	_____ Date
_____ Co-head of Household	_____ Date