

Household Questionnaire

Certification Effective Date: <input type="checkbox"/> Move-in _____ <input type="checkbox"/> Initial Cert _____ <input type="checkbox"/> Recertification _____ <input type="checkbox"/> Add a Member _____	Household certifying for the following program(s): <input type="checkbox"/> Section 8 <input type="checkbox"/> NHTF <input type="checkbox"/> Housing Tax Credit <input type="checkbox"/> HOME <input type="checkbox"/> Section 236 <input type="checkbox"/> Other _____	Date and Time Rec'd: _____ Rent Amount: \$ _____
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Property Name _____ Bldg/Unit # _____

Household Composition

Applicants/residents, complete this application in your own handwriting. List all persons who will be living in the unit. Give the relationship of each family member to the head of household. If this eligibility application is being completed by an applicant who is applying for occupancy with an existing household, only include the information for the new applicant. **Each household member age 18 years or older and under age 18 if head, spouse, or co-head of household must disclose income and assets and sign and date this application.** All Housing Tax Credit Program households must also complete an Annual Student Certification (HTC 35).

	Household Member's Name	Relationship	Date of Birth	Has/Will this person be a student* during this and/or the upcoming calendar year? YES/NO	Social Security Number
1		HEAD			
2					
3					
4					
5					
6					
7					
8					

* Include public and private elementary, junior & senior high, college, university, technical, trade, and mechanical schools. Do not include on-the-job training courses.

Household Income

List current and anticipated income for the twelve-month period beginning on the anticipated move-in date or effective date of recertification. **Include all full time, part time or seasonal income even if completing this application in the off-season.**

DOES ANY MEMBER RECEIVE OR EXPECT TO RECEIVE
(Check YES or NO to each item, as applicable, and include gross monthly amount. List sources on page 2.):

	YES	NO	Description	Gross Monthly Amount
			1. Wages, salaries (include overtime, tips, bonuses, commissions, etc.)	\$
			2. Does any member work for someone who pays them in cash or is self-employed.	\$
			3. Regular pay for a member of the armed forces	\$
			4. Public Assistance (MFIP, GA, MSA) Benefits are received by (circle one) direct deposit check cash card	\$
			5. Worker's compensation	\$
			6. Unemployment benefits or severance pay	\$
			7. Student financial assistance (public or private, not including student loans).	\$
			8. Child support (check yes if you have a court order, even if you are not receiving the full amount awarded)	\$
			9. Alimony/Spousal Maintenance	\$
			10. Social Security income (including unearned income of minor children)	\$
			11. Disability benefits including social security disability	\$
			12. Regular payments from pensions (PERA, railroad, etc.)	\$
			13. Regular payments from retirement benefits	\$
			14. Death Benefits	\$
			15. Regular payments from annuities or life insurance dividends	\$
			16. Regular payments from inheritance, insurance settlement, lottery winnings, etc.	\$
			17. Net income from rental property	\$
			18. Regular cash and non-cash contributions, assistance with paying bills (including utilities), or gifts from companies, agencies or individuals not living in the unit (not including groceries).	\$
			19. Are any changes to income expected within the next 12 months due to a raise, bonus or other reason?	\$
			20. Other (list) _____	\$

Household Assets

	YES	NO	DOES ANY HOUSEHOLD MEMBER (INCLUDING CHILDREN) HAVE MONEY HELD IN:	Current Balance
			21. Checking Accounts (6 month average balance)	\$
			22. Savings Accounts	\$
			23. Cash cards used to receive government benefits or other income	\$

Deductions and Allowances
For Section 8/236 HUD programs only

			Amount
A. Day Care			
Do you have child care expenses for child/ren under age 13 because you work, are actively seeking employment or attending school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
If yes, name and address of provider _____ _____			
\$ _____ paid per month. Is any portion paid by another person or agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
If yes, name and address of provider _____ _____			
\$ _____ paid per month. Is any portion paid by another person or agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, name and address of provider _____ _____			

B. Medical – Complete if the head of household, co-head or spouse are at least 62 years old, handicapped or disabled.			
Do you have Medicare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Do you have any other kind of medical insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
If yes, name and address of insurer _____ _____			
Do you receive medical assistance? If yes, do you have a monthly spend-down?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Do you pay for prescription medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Name and address of pharmacy: _____ _____			
Do you have any non-prescription (over the counter) medication that your doctor has requested you to use on a regular basis (e.g., insulin, aspirin, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____

Do you have any outstanding medical bills on which you are paying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
If yes, indicate the types of bills owed: _____ _____			
Do you expect to have extraordinary medical/dental expenses in the next 12 months? If yes, list the amount and type of expense:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____

Name and facility where this can be verified: _____ _____			
Doctor's name and address: _____ _____			

Please bring receipts for your non-prescription medication.

Household Questionnaire

I/We hereby certify that I/We Have Have not sold or given away any assets for less than Fair Market Value during the two year (24 month) period preceding the date of this questionnaire. Any assets sold or disposed of for less than Fair Market Value must be identified below:

Household Member	Asset and Estimated Market Value	Date sold/disposed	Amount Received
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

ADDITIONAL INFORMATION

The following questions pertain to every member of the household. Check either **YES** or **NO** in response to each question. Add an explanation below for all items checked YES.

Yes	No	Question
<input type="checkbox"/>	<input type="checkbox"/>	Will any household member, including children, live in the unit on a less than full time basis?
<input type="checkbox"/>	<input type="checkbox"/>	Do you anticipate any change in your household (someone moving in or out) during the next 12 months?
<input type="checkbox"/>	<input type="checkbox"/>	Does any adult member of the household have zero income? If yes, name(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Does/will the household receive rent assistance? If so, indicate from what source (Section 8, Rural Development RA, etc.).
<input type="checkbox"/>	<input type="checkbox"/>	Does your household have any needs that might be better served by a unit which is accessible to persons with mobility, hearing or visual impairments?
Explanation: _____ _____ _____		

SIGNATURES

I/we certify that the foregoing information is true and complete to the best of my/our knowledge, and authorize the Landlord to make inquiries to verify the statements herein. I/we further understand that any intentional misrepresentation on this form might result in a default in the rental agreement and/or eviction of this household. If any of the aforementioned information changes, I/we agree to notify Landlord immediately.

Applicant/Resident Signature _____	Date _____
Applicant/Resident Signature _____	Date _____
Applicant/Resident Signature _____	Date _____
Applicant/Resident Signature _____	Date _____
Head of household email address: _____	Phone: _____

This applicant/resident required assistance in completing the Household Questionnaire due to: _____

Assistance was provided by: _____ **Date:** _____