

SHELTON HOUSING AUTHORITY APPLICATION

PLEASE LEAVE BLANK OFFICE USE ONLY Date: _____ Time: _____ Initials: _____
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Applicant Name: _____
 Mailing Address: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____ Cell Phone: _____

Personal Declaration

This form must be completed in your own handwriting. You must use the correct legal name for each member of your household as it appears on the Social Security Card. All adult members of the household must sign below certifying the information pertaining to them. Please print.

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Household Composition

List below all household members who will be living in the unit.

(Legal Name) First Name, Middle Initial, and Last Name	Date of Birth	Relationship to Head of Household	Social Security Number	Place of Birth
HEAD				

Do you anticipate on change in your family size in the next twelve months? Yes ___ No ___
 If yes, explain changes below:

Are you separated? _____ Are you divorced? _____ If separated or divorced, fill in information of spouse/ex-spouse below, if known:

Name: _____ Name: _____
 Address: _____ Address: _____
 Social Security #: _____ Social Security: _____

GENERAL INFORMATION

HUD requires that we obtain the following information for each family member. If a member is bi-racial, we ask that you indicate all races: Please use guide to the right and indicate which numbers apply.

	<u>Race</u>	<u>Ethnicity</u>	<u>Race</u>
Head of Household	_____	_____	1 – White
Spouse/Other Adult	_____	_____	2 – Black
Household Member	_____	_____	3 – American Indian or Alaskan
Household Member	_____	_____	4 – Asian
			5 – Hawaiian/Pacific Islander
			6 – Mixed: See above paragraph.
			<i>Ethnicity: Please mark A or B.</i>
			A – Hispanic
			B – Non-Hispanic

Head of Household and/or Spouse: Please check one:
 ___ Non-Elderly ___ 62 Years or Older ___ Person with a Disability

- 1) Have you or any other adult members ever used any name(s) or Social Security number(s) other than the one you are currently using? Yes ___ No ___ If yes, explain below: _____
- 2) Are you or any adult member of your family students? Yes ___ No ___ If yes, where do you attend school? _____
- 3) Have you or any member of your family lived in assisted housing? Yes ___ No ___ If yes, list where and when? _____
Also, if yes, did you leave owing any monies for damages, past due rent or late charges in the assisted housing? Yes ___ No ___
- 4) Have you ever been requested to repay money knowingly misrepresenting information or committed any fraud in a Federally assisted housing program? Yes ___ No ___ If yes, explain : _____
- 5) Do you or any member of your household claim handicapped or disabled status for eligibility purposes? Yes ___ No ___ Do you draw SSI _____, VA Disability _____, SS Disability _____, Other _____ Explain: _____
- 6) Do you or any member of your household require a special needs dwelling unit? Yes ___ No ___ Explain: _____
- 7) How did you hear about our program? _____
- 8) Who is your caseworker at Social Services? _____

Have you or anyone listed on this application engaged in drug-related criminal activity or violent criminal activity, including criminal activity by any family member as defined below? Yes ___ No ___ If yes, please explain: _____

Crime by family members:

- (a) **At any time, the HA may deny assistance to an applicant,** or terminate assistance to a participant family if any member of the family commits:
 - (1) **Drug-related criminal activity; or**
 - (2) **Violent criminal activity**
- (b) **If the HA seeks to deny or terminate assistance** because of illegal use, or possession for personal use, of a controlled substance, such use or possession must have occurred within five years before the date that the HA provides notice to the family of the HA determination to deny or terminate assistance. The HA may not deny or terminate assistance for such use or possession by a family member, if the family member can demonstrate that he or she:
 - (1) Has an addiction to a controlled substance, has a record of such impairment, or is regarded as having such an impairment; and
 - (2) Is recovering, or has recovered from such an addiction and does not currently use or possess controlled substances. The HA may require a family member who has engaged in the illegal use of drugs to submit evidence of participation in, or successful completion of, a treatment program as a condition to being allowed to reside in the unit.
- (c) **Evidence of criminal activity.** In determining whether to deny or terminate assistance based on drug-related criminal activity or violent criminal activity, the HA may deny or terminate assistance if the preponderance of evidence indicates that a family member has engaged in such activity, regardless of whether the family member has been arrested or convicted.

INCOME INFORMATION

List all money earned or received by everyone living in your household. This includes money from wages, self-employment, child support, contributions, Social Security(including Medicare), disability payments (SSI), Worker's Compensation, retirement benefits, AFDC, Veterans benefits, rental property income, stock dividends, income from bank accounts (including CD, savings, checking, and Money Market accounts), alimony, unemployment and all other sources.

Head of Household	Spouse/Other Adult
Social Security/Medicare: \$ _____	\$ _____
Gross Wages: \$ _____	\$ _____
<i>Please indicate how often paid on gross wages.</i>	
SSI: \$ _____	\$ _____
Disability: \$ _____	\$ _____
Pension/Retirement: \$ _____	\$ _____
Rental Income: \$ _____	\$ _____
Real Estate: \$ _____	\$ _____

Names of Financial Institution(s) – Account Numbers

List: CD's, Checking, Savings, Money Market, Stocks, Bonds, IRA's, & %Of Interest

- 1) Does anyone outside of your household pay for any of your bills or give you money?
 Yes ___ No ___ If yes, please explain: _____

- 2) Do you expect to receive any other income in the next twelve (12) months?
 Yes ___ No ___ If yes, from what source? _____

- 3) Employer Name: _____
 Employer Address: _____
 Date Employed: _____ Hours: _____ Wage: _____ HR/WK/MO

- 4) Employer Name: _____
 Employer Address: _____
 Date Employed: _____ Hours: _____ Wage: _____ HR/WK/MO

ASSET INFORMATION

- 1) Do you or any household member own or have any interest in any real estate, mobile home, or personal property held as an investment (such as gems, jewelry, coin collections, antique cars, boats, ect.)? Yes ___ No ___ If yes, please explain _____
- 2) Have you sold any real estate or disposed of any asset in the last two years? Yes ___ No ___ If yes, please explain _____
- 3) Do you own vehicle(s)? _____ Make/Model/Year _____
Make/Model/Year _____ License Plate #'s _____

MISCELLANEOUS INFORMATION

- 1) Do you or any member of your household claim handicapped or disabled status for eligibility purposes? Yes ___ No ___
- 2) Do you or any member of your household require a mobility free dwelling unit? Yes ___ No ___
- 3) Do you smoke?
Notice to smokers: In accordance with HUD PIH notice 2017-03 All Public Housing Agencies administering public housing are “Smoke Free” Properties. Smoking is prohibited at a limit of 25 feet from windows and doors and within any distance of common areas in accordance to this public housing agency’s policy.
- 4) Do you have Medicare? Yes ___ No ___ If yes, what is your Medicare number? _____
- 5) Do you receive medical assistance through the welfare department (Medicaid)? Yes ___ No ___
- 6) Do you have medical bills on which you are paying on a regular basis? Yes ___ No ___
- 7) Do you expect to have any medical expenses during the next twelve (12) months? Yes ___ No ___

THE FOLLOWING SECTION NEEDS COMPLETED FOR ELDERLY, DISABLED, OR HANDICAPPED FAMILIES ONLY:

- 1) If you pay for a health insurance plan, please give us the amount you pay, whether it is monthly, quarterly, semi-annual, annual, your account and policy numbers, and what company you have the insurance with: _____

- 2) List below all Doctors/Hospitals and their addresses plus any other medical expenses you have paid in the last twelve months and **have not** been reimbursed by Medicare, Medicaid, or health insurance: _____

- 3) If you have prescriptions, please list below the name and address of the pharmacy you go to: _____

- 4) Did Medicare or your health insurance company pay for or reimburse you for any medical expenses in the past twelve months? Yes ___ No ___ If yes, you must enclose copies of the forms your received from the insurance agency or Medicare with this application form.

RENTAL HISTORY

Present landlord(s): Name: _____
Address: _____
Phone: _____

Your previous address: _____
Street Address City State Zip

Move-In Date Move-Out Date Reason for Leaving

Previous landlord(s): Name: _____
Address: _____
Phone: _____

Your previous address: _____
Street Address City State Zip

Move-In Date Move-Out Date Reason for Leaving

Person to call in case of emergencies:

Name: _____ Relation to you: _____

Address: _____ Phone Number: _____

All Applicants: Please read the following certification statement and sign where indicated. The Executive Director will assist you with any questions you may have.

Certified Statement: The information requested on this form is being collected in connection with regulations of the Village of Shelton Housing Authority, Shelton, Nebraska authorized by the United States Department of Housing & Urban Development to determine an applicant's initial and continuing eligibility; apartment size, and the amount of contribution by the tenant(s). It will be used to provide the basis for managing the program(s), for protecting the United States Government and the City of Shelton Housing Authority's financial interest, and for verifying the accuracy of the information furnishes. It may be released to appropriate Federal, State, and local agencies; when relevant, to civil, criminal, or regulatory investigators or prosecutors. Failure to provide any information may result in a delay, or rejection of eligibility approval, or subsequent determination that initially approved eligibility erroneous. General authorization to request this information is based on the Authority granted by the United States Housing Act of 1937, as amended, 42U.S.C., 1437 et seq., the Housing and Community Development Amendments of 1981, P.L. 97-35. 85 Statute, 348, 408.

WARNING: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Applicant(s)/Tenant(s) Statement:

I do hereby swear and attest that all of the information above about me is true and correct. All adults over the age of 18 must sign the application. I also understand that all changes in the income of any member of the household as well as any changes in the household members must be reported to the City of Shelton Housing Authority in WRITING IMMEDIATELY.

Signature of Head of Household

Date

Signature of Spouse or Other Adult

Date

Signature of Other Adult

Date

Signature of Other Adult

Date

Equal Housing Opportunity

SHELTON HOUSING AUTHORITY

PIONEER APARTMENTS

306 C STREET
PO BOX 73
SHELTON, NE 68876
PHONE: 308-647-6673
Email: director@sheltonhousing.org

