



Housing Authority

of
 THE CITY OF PRICHARD, ALABAMA
 P. O. Box 10307 -- Prichard, Alabama 36610 -- (251) 456-3324
 Fax (251) 452-6149

APPLICATION FOR LEEDS STREET HOUSING

Bring this form, completed **in blue or black ink in your own handwriting** to your appointment for re-certification. Use the legal name for each person who will reside in the house as it appears on his/her Social Security card. All persons **age 18 and over** must sign this application certifying that the information pertaining to them is correct. **Do not leave any blanks.** If a section or question does not apply to you, write **NO** in it.

Name: _____ Home Phone # _____ Work Phone # _____

Mailing Address: _____ Physical Address: _____

Emergency Contact: _____ Address: _____ Phone # _____

I. HOUSEHOLD COMPOSITION (List all persons in household.)

Adults (age 18 and older)			Social Security	Relation		Race/	Birth		Disabled	Marital	Student
Last	First	MI	No.	to Head	Sex	Ethnicity	Date	Age	Yes/No	Status	Yes/No
				HEAD							

Minors (Under Age 18)			Social Security	Relation		Race/	Birth		Disabled	Name/Address of
Last	First	MI	No.	to Head	Sex	Ethnicity	Date	Age	Yes/No	Absent Parent (if applicable)

1. Is any household member age 18 or older a full time student (*other than head of household or spouse of head of household*)? yes no if yes, list name and the school they attend: _____
2. Is the *Spouse of the Head of Household* temporarily absent from the home? yes no
If yes, where? _____
3. Does anyone outside the household help with bills on a regular basis? yes no If yes, list name of each Person or agency that assists with bills: _____
4. Does anyone in your household require special accommodations due to a handicap or disability? yes no
If yes, specify requirements: _____

II. INCOME AVAILABLE TO HOUSEHOLD

List all income earned or received by everyone living in the household regardless of age. List gross amounts of income (before any deductions).

Income Source	Yes	No	Family Member	Source	Amount
Self-employment					\$
					\$
Wages or Earnings					\$
					\$
Pension or Retirement					\$
					\$
*SSI					\$
					\$
*Social Security					\$
					\$
Child Support					\$
					\$
Unemployment Benefits					\$
					\$
Worker's Compensation					\$
					\$
Alimony					\$
					\$
Income From Rental Property					\$
					\$
Babysitting or Adult Care Gift					\$
					\$
Regular Contributions or Gifts					\$
					\$
Other					\$
					\$

If you receive Social Security SSI, is it direct deposit? yes no
If yes, what is the name of the bank and the account number? _____

III. ASSETS

1. Does any household member have assets or receive any income from assets? yes no

Real Estate	<input type="checkbox"/> yes	<input type="checkbox"/> no	Stocks	<input type="checkbox"/> yes	<input type="checkbox"/> no
Trusts	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bonds	<input type="checkbox"/> yes	<input type="checkbox"/> no
Insurance Settlement	<input type="checkbox"/> yes	<input type="checkbox"/> no	Insurance Policy	<input type="checkbox"/> yes	<input type="checkbox"/> no
Retirement/Pension	<input type="checkbox"/> yes	<input type="checkbox"/> no	Certificate of Deposit	<input type="checkbox"/> yes	<input type="checkbox"/> no
Savings Account	<input type="checkbox"/> yes	<input type="checkbox"/> no	Checking Account	<input type="checkbox"/> yes	<input type="checkbox"/> no

If yes, what Bank? _____

If yes, what Bank? _____

Account Number _____

Account Number _____

Other yes no _____

2. Has an asset been given away or sold in the past 2 years? yes no

If yes, what was the asset? _____ Date: _____

What was its market value? _____ How much did you receive for it? _____

IV. QUALIFYING FOR THE EARNED INCOME EXCLUSION

(If there is not a **disabled adult** in the household, skip this section.)

1. Has any disabled adult household member started a new job *or* had an increase in earnings since last Certification? yes no If yes, who? _____ If no, skip to Section V.

2. How much did the person listed above earn in the 12 months immediately before his/her increased earnings or new Employment? _____ Where was previous employment? _____

3. Did the person listed above receive TANF benefits at any time in the six months before this employment or Increase in earnings began? yes no

4. Was the employed person participating in a self-sufficiency or job training program *at the time* he/she starting this Job or received the increase in earnings? yes no

If yes, list training program and dates of enrollment: _____

V. MEDICAL (Complete only if the Head of Household or Spouse is disabled or is 62 years of age or older)

List all medical expenses the family anticipates paying during the next 12 months that will **NOT** be reimbursed by insurance or other outside source. Do NOT include life or burial insurance premiums.

TYPE OF EXPENSE	AMOUNT	TYPE OF EXPENSE	AMOUNT
<u>Medical insurance</u>	\$ _____	<u>Doctor's Office Calls</u>	\$ _____
<u>Prescription medicine</u>	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

VI. DISABILITY ASSISTANCE EXPENSE

Do you pay for attendant care or auxiliary apparatus for a disabled household member in order for them or any other? Family member to work ? yes no if yes, Itemize: _____

VII. CHILD CARE

Do you pay for Child Care for children age 12 or younger while you work, look for work or attend school?

[] yes [] no If yes, to whom are expenses paid?

Name of Children: _____

Address of Child Care Provider: _____

How much is paid? _____

VIII. ADDITIONAL INFORMATION

Are you current with your share of the rent to the landlord? [] yes [] no

If not, explain: _____

Are all utilities in your unit (gas, electricity, water) currently turned on by the utility company? [] yes [] no

If not, specify: _____

All household members age 18 and over should review the information on this form and **MUST** sign below.
All information provided on this form is subject to verification by Prichard Housing Authority.

I do hereby swear and attest that all the information provided on this application by me and about me is true and correct. I understand that I must report any changes in income, assets, and family composition to Prichard Housing Authority in writing within 10 days of such change. I further understand that false statements or information provided by me are punishable under federal and state law and constitute grounds for termination of my housing assistance.

Signature of Head of Household Date

Signature of Spouse of Head of Household Date

Signature of Other Adult Date

Signature of Other Adult Date

Signature of Other Adult Date

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENT TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity national toll-free hotline at 1-800-669-9777.