



Personal Declaration INTERIM

Please use this form to report changes in your household or income

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.

PHONE #: _____

E-mail: _____

HOUSEHOLD COMPOSITION: List all persons who will be living in your home beginning with head of household and other adults first. Children are listed in the second table.

ADULTS (AGE 18 & OVER) – Legal Name	SEX (M or F)	BIRTHDATE	SOCIAL SECURITY #	RELATIONSHIP TO HEAD OF HOUSEHOLD	RACE (Indicate # below)	ETHNICITY 1-Hispanic or Latino 2-Not-Hispanic or Latino
1)				Self		
2)						
3)						
4)						

Optional RACE NUMBERS: 1-White, 2-Black or African American, 3-American Indian or Alaska Native, 4-Asian, 5-Native Hawaiian or Other Pacific Islander, 6-Other **Optional=Gender**

CHILDREN – Legal Name	SEX (M or F)	BIRTHDATE	SOCIAL SECURITY #	RELATIONSHIP TO HEAD OF HOUSEHOLD	RACE (Indicate # below)	ETHNICITY 1-Hispanic or Latino 2-Not-Hispanic or Latino
1)						
2)						
3)						
4)						
5)						
6)						

RACE NUMBERS: 1-White, 2-Black or African American, 3-American Indian or Alaska Native, 4-Asian, 5-Native Hawaiian or Other Pacific Islander, 6-Other

WHAT ARE YOU CHANGING OR COMMENTS: (if after completing page 1 & 2, you still need room to write, you may use this section)

- Adding/subtracting a family member
 New job/lost job
 Other, please explain

The following was approved by our Board of Directors 2-27-08 to the Section 8 Administrative Plan: In regards to changes to income, "The Housing Authority of the City of Loveland must receive the required documentation by the 25th of the month in order for the decrease to be effective the 1st of the following month. Written requests for review of circumstances beyond client control will be considered."

EMPLOYMENT:

List all employed family members:

Name

Employer

Address

Phone Number

1.

2.

3.

OTHER SOURCES OF INCOME: Please check those that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> TANF | <input type="checkbox"/> Social Security | <input type="checkbox"/> (SSI), Supplemental Security Income |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Veterans Benefits | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> (AND) Disability | <input type="checkbox"/> Alimony | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> PERA, Retirement | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pensions | <input type="checkbox"/> (OAP) Old Age Pension | |

Does anyone outside of your household pay for any of your bills or give you money? Y or N

Note: If your dependent receives Social Security or SSI, you must report that as well

ASSETS:

- | | |
|--------------------------|---------------------|
| Checking Account # _____ | Name of Bank: _____ |
| | Address: _____ |
| Savings Account # _____ | Name of Bank: _____ |
| | Address: _____ |
| Certificates | Name of Bank: _____ |
| | Address: _____ |
| Stocks/Bonds | Value \$: _____ |

SOURCES OF ALLOWANCE:

Families

_____ Child Care or Day Care If yes, list provider with phone number.

Elderly, Handicapped, and Disabled only

- Medical Insurance Premiums
- Prescription drugs
- Outstanding medical bills (payment plan)
- Continuing medical expenses (regular visits)
- Medicare-Approved Drug Discount Card

APPLICANT/PARTICIPANT CERTIFICATION: I/We certify that all information regarding my family size and income is true and complete to the best of my knowledge and belief. I understand that knowingly supplying false, incomplete, or inaccurate information is grounds for termination of housing assistance, or termination of tenancy.

Signature of adult Date

Signature of adult Date

Signature of adult Date