PERSONAL DECLARATION - ANNUAL

If you are disabled/handicapped and need assistance in completing your declaration STOP HERE and ask one of the staff to assist you.

Head of household must complete this form. **PLEASE PRINT AND READ CAREFULLY.** 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.

HEAD OF HOUSEHOLD: _____ Email address: _____

STREET ADDRESS: _____ Phone number: _____

CITY/STATE/ZIP: _____ Other phone number: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION. FAILURE TO COMPLETE THE DECLARATION IN DETAIL MAY CAUSE YOU TO BE DETERMINED INELIGIBLE AND/OR LEASE TO BE TERMINATED. **COMPLETE THE SHADED AREAS FOR EACH PERSON IN THE HOUSEHOLD. IF YOU ARE ADDING SOMEONE TO YOUR HOUSEHOLD PLEASE PROVIDE ALL OF THEIR INFORMATION.**

PLEASE LIST ALL PERSONS WHO WILL BE RESIDING IN YOUR HOUSEHOLD - HEAD OF HOUSEHOLD LISTED FIRST:

FULL NAME - FIRST M.I. LAST	RELATIONSHIP	SEX	SOCIAL SEC #	DATE OF BIRTH	AGE	CITY/STATE OF BIRTH
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS.

Does anyone live with you now who is not listed above? If yes please explain:

Are there any changes in your income or household? If yes, please explain:

Have you or any household member sold or given away any real estate property or assets in the past 2 years? If yes, please explain:

Have you or any household member been convicted for any drug-related or violent criminal activity within the past twelve months? If yes, please explain:

Is any member of your household employed full time, part time, or seasonally? If yes, who?

Does any member of your household expect to work for any period during the next 12 months? If yes, who?

Is any member of your household on leave of absence from work due to lay off, medical, or military leave? If yes, who?

Does any member of your household work for someone who pays in cash? If yes, who?

Does any member of your household now receive or expect to receive unemployment benefits? If yes, who?

Does any member of your household now receive child support? If yes, who and in what county?

Does any member of your household have a child support order that is not being paid? If yes, who and in what county?

Does any member of your household receive or expect to receive assistance from Jobs & Family Services? If yes, who?

Does any member of your household receive alimony? If yes, who?

Does any member of your household receive or expect to receive Social Security or SSI? If yes, who?

Does any member of your household receive income from a pension or an annuity? If yes, who?

Does any member of your household receive regular cash contributions from an individual or an agency? If yes, who?

Does any member of your household receive income from assets including interest on checking or savings accounts? Interest or dividends from certificates of deposit, stocks or bonds, income from rental property? If yes, who

COMPLETE THE SHADED AREAS. DO NOT LEAVE ANYTHING BLANK. IF IT DOES NOT APPLY PUT N/A.

LIST ALL CHECKING AND SAVINGS ACCOUNTS INCLUDING IRA, KEOUGH ACCOUNTS AND CERTIFICATES OF DEPOSIT, OF ALL HOUSEHOLD MEMBERS, INCLUDING AMOUNTS DISPOSED OF DURING THE PAST TWO YEARS:

FAMILY MEMBER	BANK NAME	ACCOUNT NUMBER	BALANCE

FOR EACH TYPE OF INCOME THAT YOUR HOUSEHOLD RECEIVES, GIVE THE SOURCE OF INCOME AND THE AMOUNT OF INCOME RECEIVED:

FAMILY MEMBER	SOURCE OF INCOME / EMPLOYER	WEEKLY	BI-WEEKLY	MONTHLY, ETC.

FOR EACH TYPE OF EMPLOYMENT LIST THE FOLLOWING INFORMATION:

EMPLOYER	COMPLETE ADDRESS	CONTACT PERSON	PHONE #	FAX #

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS.

Do you pay for childcare which allows you or another family member to work or go to school? If yes, give name, address and telephone number of childcare provider and the weekly amount you pay.

Do you pay for a care attendant or for any equipment for any disabled/handicapped member of the family necessary to permit that person or someone else in the family to work? If yes, please explain:

Do you have any medical bill(s), prescriptions, medical insurance, or a medical spend down with Jobs & Family Services you are paying for an ELDERLY OR DISABLED member in your household? If yes, please explain:

Do you wish to declare that you or someone in your household is disabled? If yes, please explain who and see your Housing Coordinator for verification process.

Are there members of your household who are the age of 18 or older and a full-time student? Please list the household members name and the name of the school they attend.

CERTIFICATION

I/WE certify that the above information is true to the best of my knowledge and belief. I/WE understand that the above information is being collected to determine the continuation of eligibility. I/WE authorize the program to verify all information provided on this declaration and to release information to appropriate Federal, State, or local agencies.

I/WE understand that false statements or information will result in the termination of any assistance and are punishable under Federal Law. I also understand that all changes in income of any member of the household as well as any changes in the household members must be reported to the BMHA office, IN WRITING, IMMEDIATELY.

Head of Household _____ Date _____ Spouse/Other Adult _____ Date _____

Other Adult _____ Date _____ Other Adult _____ Date _____

I have reviewed this declaration with the applicant/resident and after review of all required documentation, have determined this applicant/resident to be eligible for assistance.

BMHA Coordinator _____ Date _____

WARNING! TITLE 18, SECTION 1001 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.

Butler Metro
housing authority

SPONSOR FORM

To Whom It May Concern:

I _____ authorize _____ — In the event of my death to enter in and claim or dispose of my belongings at:

ADDRESS:

This same person will, if necessary, be responsible to move me and my belongings from my dwelling unit should I become unable to care for myself.

Relationship to Resident: _____

Contacts Printed Name: _____ Phone Number: _____

Contacts Address: _____

City/State/Zip: _____

DO NOT SIGN UNTIL IN THE PRESENCE OF A NOTARY

_____ _____

Resident Signature Date

State of Ohio – County of Butler

The foregoing instrument was acknowledged before me this _____ day of _____ 20 ____ __ by _____.

My commission expires: _____.

Notary Signature: _____.

Hamilton: (513) 896-4411 Middletown: (513) 422-2341 4110 Hamilton-Middletown Road Hamilton, OH 45011-6218 www.butlermetro.org

Authorization for the Release of Information/ Privacy Act Notice

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

OMB CONTROL NUMBER: 2501-0014
exp. 07/31/2017

PHA requesting release of information; (Cross out space if none) (Full address, name of contact person, and date)	IHA requesting release of information: (Cross out space if none) (Full address, name of contact person, and date)

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

PHA-owned rental public housing
Turnkey III Homeownership Opportunities
Mutual Help Homeownership Opportunity
Section 23 and 19(c) leased housing
Section 23 Housing Assistance Payments
HA-owned rental Indian housing
Section 8 Rental Certificate
Section 8 Rental Voucher
Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not mc than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, ag the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING
This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ Check this box if you choose not to provide the contact information.

Signature of Applicant	**Date**

Butler Metro
housing authority

GENERAL RELEASE FORM

I hereby authorize/direct The Hamilton/Middletown Police Department, or any other Federal, state, or local agency, organization, business, or individual, to release any information needed to determine my eligibility for housing or continued occupancy with Butler Metropolitan Housing Authority.

Por la presente autorizo directa el Departamento de policía de Hamilton/Middletown, o cualquier otro Federal, estado, o agencia, organización, negocio o individuo, para liberar cualquier información necesaria para determinar mi elegibilidad para uso de vivienda o continuar con Autoridad de vivienda metropolitana de Butler.

I authorize you to release as applicable, any credit, financial, employment information relating to my previous housing tenancy, credit information, my personal or family's conduct including criminal records or drug abuse. This information is to be used solely by Butler Metropolitan Housing Authority to determine whether or not I qualify as an applicant or for continued occupancy as a resident. It will not be disclosed outside the agency without my consent, but may be viewed by authorized employees or representatives of the U.S. Department of HUD, as applicable.

Autorizo a soltar según sea el caso, crédito, financiera, empleo información relacionada con mi anterior tenencia de la vivienda, información de crédito, mi personal o conducta de la familia como antecedentes penales o abuso de drogas. Esta información debe ser utilizado únicamente por la autoridad de vivienda metropolitana de Butler para determinar si o no calificar como un candidato para ocupación continua como residente. No será revelada fuera de la agencia sin mi consentimiento, pero puede ser visto por los empleados autorizados o representantes de los Estados Unidos Departamento de HUD, según sea el caso.

I understand, depending on Butler Metropolitan Housing Authority's policies and requirements, that verification of information for household or may be required. I agree that a photocopy of this authorization may be used for the purposes stated above.

I entender, según de Butler metropolitana autoridad de vivienda las políticas y requisitos, esa verificación de la información para el hogar o puede ser necesario. Estoy de acuerdo que una fotocopia de esta autorización puede utilizarse para los fines indicados anteriormente.

Signature Head of Household	Date
Signature Co-Head/Other Adult	Date
Signature Other Adult	Date
Signature Other Adult	Date

Butler Metro
housing authority

BMHA Community Service Requirement
Certification of Exemption Status

This form is to be completed by the head of household and/or every household member between the ages of 18 and 62 who is currently reporting employment income, but claims exemption from BMHA's Community Service Requirement.

Federal law requires that all non-exempt adult residents of federally funded public housing complete 8 hours of community service activities each month. Therefore, BMHA will annually determine whether or not household members are exempt from this requirement.

_____, who resides at, _____ is eligible for an exemption to
Name Address

BMHA's Community Service Requirement because he/she meets the following criteria:

(Check any of the following that apply)

[ ] 1. Family members who are 62 years of age or older;

[ ] 2. Family members who are blind or disabled;

[ ] 3. Family members who are the primary caregivers for someone who is blind and/or disabled;

[ ] 4. Family members engaged in a work activity;

[ ] 5. Family members who are exempt from work activity under Part A, Title IV of the Social Security Act or under any other State Welfare Program, including the Welfare to Work program;

[ ] 6. Family members receiving assistance under a State Program funded under Part A, Title IV of the Social Security Act or under any other State Welfare Program, including Welfare to Work and who are in compliance with that program.

I attest that the above information is accurate.

Name: _____
Address: _____

_____ _____
Signature Date

Butler Metro
housing authority

Attachment A

Community Services and Self-Sufficiency Requirement Certification
For Non-Exempt Individuals

ENTRANCE ACKNOWLEDGEMENT

Date: _____
Participant Name: _____

I have received and read the Community Service and Self Sufficiency Requirement. I understand that as a resident of public housing, I am required by law to contribute 8 hours per month of community service or participate in an economic self-sufficiency program. I further understand that if I am not exempt, failure to comply with CSSR is grounds for lease nonrenewal. My signature below certifies I received notice of this requirement at the time of initial program participation.

Signature: _____ Date: _____

Butler Metro
housing authority

Attachment B

Community Services and Self-Sufficiency Requirement Certification
For Non-Exempt Individuals

Annual Renewal

Date: _____

Participant Name: _____

I understand that as a resident of public housing, I am required by law to contribute 8 hours per month of community service or participate in an economic self-sufficiency program. I certify I have complied with this requirement.

Signature: _____

Date of Signature: _____

Butler Metro
housing authority

WHOLE LIFE POLICY VERIFICATION

INSURANCE COMPANY: _____

The Housing Authority is required by Federal Regulations to verify cash value on all insurance policies for Public Housing Applicants and Residents. Please complete this form and return it to our office as soon as possible.

APPLICANT/RESIDENT NAME: _____ SSN: _____
ADDRESS: _____

RELEASE OF INFORMATION

I HEREBY GUVE PERMISSION TO RELEASE ALL VERIFICATIONS OF MY INSURANCE POLICIES, BALANCES AND INTEREST EARNED, TO THE BUTLER METROPOLITAN HOUSING AUTHORITY.

APPLICANT/RESIDENT SIGNATURE: _____ DATE: March 18, 2020

POLICY NUMBER:			
TYPE OF ACCOUNT:			
DATE OPENED:			
CASH VALUE:			
FACE VALUE:			
DATE CLOSED:			

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: _____

Butler Metro
housing authority

VERIFICATION OF VETERANS BENEFITS

TO: VETERANS

Fax:

Date: _____

Request for Release of Information from Claimant's Records

I hereby authorize the Veterans Administration to furnish the following information, which is necessary for my participation in a Federal Housing program.

_____ _____
Signature of Applicant/Participant Date

Name: _____ **SSN:** _____

Address: _____

The above named person is an applicant for, or participant in a federally-assisted housing program operated by the Housing Authority. In order to calculate his/her income, we need your assistance in completing this form.

To be completed by Veterans Administration

1. Compensation (service connected) [ ] Disability [ ] Death [ ] Dependency & Indemnity
   Pension (non-service connected) [ ] Disability [ ] Death
   Effective date of current award: _____
2. Allowance for Education Training: [ ] School [ ] On the job Monthly Amount $_____
   Effective date of current award: _____ Ending date: _____
   Name of training institution: _____
   Name & address of employer: _____
3. Other payments: _____
4. If any change is contemplated, please explain: _____
5. Remarks: _____

Butler Metro
housing authority

PENSION VERIFICATION

Date: _____

Pension Name: _____

NAME: _____
SSN: _____

Claim # : _____

The above named person is an applicant for, or a participant in, a federally-assisted housing program operated by the Housing Authority. In order to determine his/her eligibility and rent payment, we must verify all sources of income. Thank you for your assistance.

I do hereby authorize you to release the information requested below directly to the Housing Authority.

_____ _____
Signature Date

VERIFICATION

Type of Pension: _____

Date of Entitlement to monthly pension: _____

Current gross per month: $ _____

Date of anticipated increase: _____ Amount $ _____

Expected duration of pension: _____.

Frequency of change in amount: _____.

_____ _____
Signature of Authorized Representative Date

_____
Title

Butler Metro
housing authority

EMPLOYMENT VERIFICATION

Employer: _____ Date: _____

Address: _____ Employee: _____

SSN: _____

Phone: _____ Fax: _____

I do hereby authorize you to release the information requested below directly to the Butler Metropolitan Housing (BMHA) Leasing Department

Name: _____ Signature: _____

Print Name Signature This consent form expires 15 months after SIGNED/Date

_____ _____ Phone: _____

BMHA LEASING REPRESENTATIVE EMAIL

FAX: 513-868-5290

***** FOLLOWING TO BE COMPLETED BY EMPLOYER ONLY*****

Employer needs to furnish the following information

MY SIGNATURE BELOW INDICATES THAT THE INFORMATION BEING PROVIDED IS CORRECT	
SIGNATURE:	DATE:
TITLE:	PHONE#:

EMPLOYER NEEDS TO COMPLETE – WORK SCHEDULE

DATE STARTED:	DATE STOPPED:
NUMBER OF HOURS WORKED PER PAY PERIOD _____	TOTAL AMOUNT PAID BY EMPLOYEE PER PAY PERIOD FOR HEALTH INSURANCE. (MEDICAL, DENTAL, VISION)
RATE PER HOUR: $	
AVERAGE TIPS OR COMMISSION PER PAY: $	PAID (CIRCLE ONE) DAILY, WEEKLY, BI-WEEKLY, SEMI-MONTHLY, MONTHLY
CURRENT AVERAGE WAGES/SALARY: $	YEAR TO DATE EARNINGS:$

EMPLOYMENT INFORMATION MUST BE COMPLETED BY EMPLOYER (PLEASE COMPLETE ALL THAT APPLY)

CURRENTLY EMPLOYED: YES NO (PLEASE CIRCLE)	NO LONGER EMPLOYED EFFECTIVE: _____ REASON:
BETWEEN ASSIGMENTS AS OF:	DATE & AMOUNT OF FINAL PAY:
LAID OFF ON:	ON LEAVE OF ABSENCE SINCE: _____ PAID OR UNPAID?

EMPLOYER PLEASE PROVIDE PAY INFORMATION (LAST 6 (SIX) GROSS AMOUNTS AND PAY DATES)

DATE RECEIVED	GROSS $ AMOUNT	DATE RECEIVED	GROSS $ AMOUNT
1.		4.	
2.		5.	
3.		6.	

Butler Metro
housing authority

APPLICANT/RESIDENT CERTIFICATION FOR CHILD CARE EXPENSES

Child care provider: _____

Child care provider address: _____

Child care phone number: _____ Fax: _____

Resident Name: _____

Resident address: _____

Resident City/State/Zip: _____

I do hereby authorize the release of all information requested by the Housing Authority for the purpose of determining my eligibility for housing assistance.

Resident Signature: _____ Date: _____

The Butler Metropolitan Housing Authority is a federally-funded agency assisting qualified families with rent subsidies. The above named person is an applicant for, or participant in, a federally-assisted housing program operated by the Housing Authority. All income and expenses reported to the Authority must be verified in writing to determine his/her eligibility and rent payment. Please complete the lower part of this form and return it to: BMHA 4110 Hamilton-Middletown Rd. Hamilton, Ohio 45044 or by fax: (513) 868-5290 to: _____

Number of children in childcare: _____

Average hours per week child care is provided: _____

Weekly amount paid for child care by resident: _____

Signature of childcare provider: _____ Date: _____

Butler Metro
housing authority

Bank Verification

DATE: _____

Bank _____
Bank Fax: _____

The Housing Authority is required by Federal Regulations to verify all current bank balances and interest earned for Public Housing Applicants and Residents. Please complete this form and return it to our office as soon as possible.

Applicant/Resident Name: _____ SSN: _____

Address: _____ City/State/Zip: _____

RELEASE OF INFORMATION
I HEREBY GIVE PERMISSION TO RELEASE ALL VERIFICATIONS OF MY BANK ACCOUNTS, BALANCES, AND INTEREST EARNED, TO THE BUTLER METROPOLITAN HOUSING AUTHORITY.

SIGNATURE: _____ **DATE:** _____

*** DO NOT WRITE BELOW THIS LINE. BANK USE ONLY***

	Checking 6-Month Avg.	Savings Current Amount	Other
ACCOUNT NUMBER			
TYPE OF ACCOUNT			
DATE ACCOUNT OPENED			
CURRENT BALANCE			
ANNUAL % RATE			
INTEREST EARNED YTD			
DATE ACCOUNT CLOSED			

SIGNATURE OF AUTHORIZED PERSON: _____ Date: _____

Butler Metro
housing authority

Name: _____ Address: _____
City: _____ State: ___ Zip: _____

I (we) hereby certify that I (we) do not individually receive income from any of the following sources:

Wages from employment (including commissions, tips, bonuses, fees, etc.)
Income from operation of a business
Rental income from real or personal property
Interest or dividends from assets
Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits
Unemployment or disability payments
Public Assistance payments
Periodic allowances such as alimony, child support, or gifts received from persons not living in my household
Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc.)
Any other source not named above

I (we) currently have no income of any kind and there is no imminent change expected in my financial status or employment status during the next 12 months.

I (we) will be using the following sources of funds to pay for rent and other necessities: _____

_____.

Under penalty of perjury, I (we) certify that the information presented in this certification is true and accurate to the best of my (our) knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of assistance.

_____	_____	_____
Signature of applicant/participant	Print Name	Date
_____	_____	_____
Signature of other household member (if applicable)	Print Name	Date

***_*This statement must be signed before a Notary Public. Form will not be accepted without the notary seal.*_ ***

State of Ohio – County of Butler
The foregoing instrument was acknowledged before me this _____ day of _____

20_____ by _____.

My commission expires: _____.

Signature of Notary Public: _____.

Butler Metro
housing authority

80869-394

JOB AND FAMILY SERVICES BENEFITS SELF DECLARATION

I _____, wish to self-certify my benefits received from JOB AND FAMILY SERVICES as follows:

ALL QUESTIONS MUST HAVE AN ANSWER

I receive my benefits through _____ County. In the state of _____.

I receive CASH ASSISTANCE (OWF, TANF, DFA, etc.) [ ] No [ ] Yes – monthly amount $_____

My CASH ASSISTANCE (OWF, TANF, DFA, etc.) was sanctioned [ ] No [ ] Yes. Date sanction began _____. Length of sanction _____.

I receive FOOD STAMPS [ ] No [ ] Yes – monthly amount $_____.

I receive a DAYCARE VOUCHER [ ] No [ ] Yes My monthly co-pay is $_____.

Do not sign until in the presence of a Notary.

_____ _____
Signature Head of Household Date

_____ _____
Signature Co-Head of Household Date

_____ _____
Signature Other Adult Date

State of Ohio – County of Butler
The foregoing instrument was acknowledged before me this _____ day of _____ 20_____

by _____. My commission expires _____

_____
Notary Signature

Butler Metro
housing authority

Date: _____

CHILD SUPPORT AGENCY: _____ Fax: _____

This is to request information on child support order(s) for the following:

NAME: _____ SSN: _____

ADDRESS: _____

_____

I hereby approve the release of the requested information: _____
Resident Signature

PLEASE PROVIDE PROOF OF ANY ORDERS WITH PAYMENT HISTORY FOR THE LAST YEAR

If there is an order with no payment being received, please check below verifying the attempt to collect in one of the following ways.

[ ] Statement that collection has been attempted by the court

[ ] Child Support Bureau

[ ] Legal Guardian or Parent

Date action was initiated: _____

_____ _____
Child Support Representative Date