

# APPLICATION FOR RE-CERTIFICATION

THE HOUSING AUTHORITY OF THE CITY OF CHARLESTON

(    ) **PUBLIC HOUSING**

(    ) **SECTION 8 HOUSING CHOICE VOUCHER**

**NAME OF HEAD OF HOUSEHOLD :** \_\_\_\_\_

**HOME TELEPHONE NUMBER :** \_\_\_\_\_

**WORK TELEPHONE NUMBER :** \_\_\_\_\_

**CELLULAR NUMBER :** \_\_\_\_\_

**PAGER NUMBER :** \_\_\_\_\_

**STREET ADDRESS :** \_\_\_\_\_

**CITY, STATE, & ZIP CODE :** \_\_\_\_\_

**EMERGENCY CONTACT (NAME) :** \_\_\_\_\_

**TELEPHONE NUMBER :** \_\_\_\_\_

**STREET ADDRESS :** \_\_\_\_\_

**CITY, STATE, & ZIP CODE :** \_\_\_\_\_

## HOUSEHOLD COMPOSITION

NAME	RELATIONSHIP (to head)	SSN	RACE ( * )	ETHNICITY ( # )	DOB	AGE	DISABLED?	STUDENT?

( \* ) = AI (American Indian) / AN (Alaska Native) / A (Asian) / AA (African-American) / NHa (Native Hawaiian) / PI (Pacific Islander) / W (White)  
 ( # ) = H (Hispanic) / NHi (Non-Hispanic)

1) ARE ANY MEMBERS OF THE HOUSEHOLD LIVE-IN AIDES? \_\_\_\_\_ IF YES, LIST NAMES : \_\_\_\_\_

2) ARE ANY MEMBERS OF THE HOUSEHOLD FOSTER CHILDREN? \_\_\_\_\_ IF YES, LIST NAMES : \_\_\_\_\_

3) IF ANY MEMBER(S) OF THE HOUSEHOLD 18 YEARS OF AGE OR OLDER (EXCLUDING HEAD OR SPOUSE) WERE SHOWN AS BEING FULL-TIME STUDENTS, LIST THE NAME(S) AND ADDRESS(ES) OF THE INSTITUTION(S) THEY ATTEND : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4) IS ANY MEMBER OF THE HOUSEHOLD TEMPORARILY ABSENT? \_\_\_\_\_ IF YES, EXPLAIN THE CIRCUMSTANCES, ALONG WITH THE ADDRESS WHERE THE FAMILY MEMBER(S) ARE CURRENTLY LIVING AND THE DATE OF THEIR ANTICIPATED RETURN :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) DOES ANY MEMBER OF THE HOUSEHOLD REQUIRE A SPECIAL ACCOMMODATION DUE TO A HANDICAP OR DISABILITY? \_\_\_\_\_ IF YES, SPECIFY WHAT REQUIREMENTS ARE NEEDED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6) LIST ALL VEHICLES THAT HOUSEHOLD MEMBERS WILL HAVE PARKED AT YOUR RESIDENCE:

REGISTERED OWNER	MAKE	MODEL	COLOR	TAG #

7) (PUBLIC HOUSING ONLY) : DO YOU OWN A PET? \_\_\_\_\_ IF YES, DESCRIBE : \_\_\_\_\_

8) DOES ANYONE OUTSIDE OF THE HOUSEHOLD ASSIST WITH THE PAYMENT OF ROUTINE BILLS (UTILITIES, CABLE, TELEPHONE, ETC.)? \_\_\_\_\_ IF YES, ENTER THE INFORMATION UNDER "INCOME" ("OTHER").

9) ARE ALL OF THE UTILITY SERVICES (ELECTRICITY, GAS, WATER) CURRENTLY ACTIVE? \_\_\_\_\_ IF NO, EXPLAIN \_\_\_\_\_

# EARNED INCOME DISALLOWANCE

## SECTION 8 ONLY

- 1) HAS ANY MEMBER OF YOUR HOUSEHOLD WHO IS A PERSON WITH DISABILITIES AND WHO WAS "PREVIOUSLY UNEMPLOYED" (NOT MORE THAN WHAT COULD BE EARNED WORKING TEN (10) HOURS PER WEEK FOR FIFTY (50) WEEKS AT THE ESTABLISHED MINIMUM WAGE (\$5.25 PER HOUR) ) FOR THE MOST RECENT ONE OR MORE YEARS, NOW OBTAINED EMPLOYMENT? \_\_\_\_\_ IF NO, GO TO QUESTION #2. IF YES, LIST THE NAME(S) OF THE INDIVIDUAL(S) AND THEIR PLACE(S) OF EMPLOYMENT : \_\_\_\_\_  
\_\_\_\_\_
- 2) HAS ANY MEMBER OF YOUR HOUSEHOLD WHO IS A PERSON WITH DISABILITIES EXPERIENCED AN INCREASE IN EARNINGS, AND WHOSE EARNINGS INCREASED DURING PARTICIPATION IN AN ECONOMIC SELF-SUFFICIENCY PROGRAM OR OTHER JOB TRAINING PROGRAM? \_\_\_\_\_ IF NO, GO TO QUESTION #3. IF YES, LIST THE NAME(S) OF THE INDIVIDUALS AND FACTS SURROUNDING THE PARTICIPATION IN THE ECONOMIC SELF-SUFFICIENCY OR JOB TRAINING PROGRAM : \_\_\_\_\_  
\_\_\_\_\_
- 3) HAS ANY MEMBER OF YOUR HOUSEHOLD WHO IS A PERSON WITH DISABILITIES AND WHO HAS RECEIVED TANF BENEFITS OR SERVICES WITHIN THE PAST SIX (6) MONTHS EXPERIENCED NEW EMPLOYMENT OR ANY INCREASED EARNINGS? \_\_\_\_\_ IF NO, PROCEED TO "INCOME". IF YES, LIST THE NAME(S) OF THE INDIVIDUALS AND THE FACTS SURROUNDING THE NEW EMPLOYMENT OR INCREASED EARNINGS : \_\_\_\_\_  
\_\_\_\_\_

## PUBLIC HOUSING ONLY

- 1) HAS ANY MEMBER OF YOUR HOUSEHOLD WHO WAS "PREVIOUSLY UNEMPLOYED" (NOT MORE THAN WHAT COULD BE EARNED WORKING TEN (10) HOURS PER WEEK FOR FIFTY (50) WEEKS AT THE ESTABLISHED MINIMUM WAGE (\$5.25 PER HOUR) ) FOR THE MOST RECENT ONE OR MORE YEARS, NOW OBTAINED EMPLOYMENT? \_\_\_\_\_ IF NO, GO TO QUESTION #2. IF YES, LIST THE NAME(S) OF THE INDIVIDUAL(S) AND THEIR PLACE(S) OF EMPLOYMENT : \_\_\_\_\_  
\_\_\_\_\_
- 2) HAS ANY MEMBER OF YOUR HOUSEHOLD EXPERIENCED AN INCREASE IN EARNINGS, AND WHOSE EARNINGS INCREASED DURING PARTICIPATION IN AN ECONOMIC SELF-SUFFICIENCY PROGRAM OR OTHER JOB TRAINING PROGRAM? \_\_\_\_\_ IF NO, GO TO QUESTION #3. IF YES, LIST THE NAME(S) OF THE INDIVIDUALS AND THE FACTS SURROUNDING THE PARTICIPATION IN THE ECONOMIC SELF-SUFFICIENCY OR JOB TRAINING PROGRAM : \_\_\_\_\_  
\_\_\_\_\_
- 3) HAS ANY MEMBER OF YOUR HOUSEHOLD WHO HAS RECEIVED TANF BENEFITS OR SERVICES WITHIN THE PAST SIX (6) MONTHS EXPERIENCED NEW EMPLOYMENT OR ANY INCREASED EARNINGS? \_\_\_\_\_ IF NO, PROCEED TO "INCOME". IF YES, LIST THE NAME(S) OF THE INDIVIDUALS AND THE FACTS SURROUNDING THE NEW EMPLOYMENT OR INCREASED EARNINGS : \_\_\_\_\_  
\_\_\_\_\_

# INCOME

(LIST THE INCOME OF ALL HOUSEHOLD MEMBERS, REGARDLESS OF AGE. IF REPORTED INCOME IS \$0., COMPLETE ZERO INCOME CHECKLIST FORM)

NAME	WAGES	SELF-EMPLOYMENT	RETIRE.	SSI	SOC.SEC.	CHILD SUPPORT	TANF	ALIMONY	WORKMAN'S COMP.	NON-CASH CONTR.	UNEMPL.	OTHER

HAVE YOU FAILED TO REPORT ANY INCOME RECEIVED BY ANY MEMBER OF YOUR HOUSEHOLD DURING THE PAST TWELVE (12) MONTHS? \_\_\_\_\_ IF NO, PROCEED TO "ASSETS". IF YES, LIST THE SOURCE AND AMOUNT AND BY WHOM : \_\_\_\_\_ IS YOUR RENT AND/OR ANY OTHER CHARGES PAID UP-TO-DATE? \_\_\_\_\_ IF YES, PROCEED TO "ASSETS". IF NO, WHAT IS OWED? \_\_\_\_\_

**NOTE: SCESC FORMS ARE TO BE SENT ON ALL HOUSEHOLD MEMBERS 18 YEARS OF AGE OR OLDER WHO ARE UNEMPLOYED OR NOT FULL-TIME STUDENTS**

# ASSETS

NAME	SAVINGS	CHECK.	TRUSTS	LIFE INS.	STOCKS	BONDS	REAL EST	CD's	RETIREMENT ACCT.	LOTTERY WINNINGS	INHERITANCES	OTHER

HAVE ANY ASSETS BEEN SOLD OR GIVEN AWAY IN THE PAST TWO (2) YEARS? \_\_\_\_\_ IF NO, PROCEED TO "EXPENSES". IF YES, WHAT WAS THE ASSET SOLD? \_\_\_\_\_ FOR WHAT AMOUNT WAS IT SOLD? \_\_\_\_\_ WHAT WAS THE "MARKET VALUE" WHEN SOLD? \_\_\_\_\_

# EXPENSES

(TO BE INCURRED DURING THE NEXT TWELVE (12) MONTHS AND THAT WILL NOT BE REIMBURSED BY INSURANCE OR OTHER OUTSIDE SOURCES; EXCLUDING CHILDCARE, CONSIDERED ONLY IF HEAD OF HOUSEHOLD OR SPOUSE IS HANDICAPPED OR 62 YEARS OF AGE OR OLDER)

NAME	CHILDCARE ( * )	WHEELCHAIRS &/OR RAMPS	DOCTOR	HOSPITAL	HEALTH INSUR.	MEDICATIONS	GLASSES	HEARING AIDS	DENTAL	OTHER

( \* ) IN SUPPORT OF CHILDREN TWELVE (12) YEARS OF AGE OR YOUNGER, FOR THE PURPOSES OF EMPLOYMENT, SEEKING EMPLOYMENT, OR ATTENDING SCHOOL

**HAVE YOU BEEN ISSUED A PRESCRIPTION DRUG CARD OR RECEIVED TRANSITIONAL ASSISTANCE (MEDICARE RECIPIENTS ONLY)? \_\_\_\_\_**

**( ) THE TENANT HAS REQUESTED FOR CHA PERSONNEL TO COMPLETE THIS APPLICATION ON THEIR BEHALF. THE INFORMATION CONTAINED HEREIN HAS BEEN VERBALLY RELAYED TO THE CHA FIRST-HAND BY THE TENANT. PRIOR TO AFFIXING THEIR SIGNATURE, THE TENANT HAS REVIEWED THE CONTENTS OF THE DOCUMENT. THEIR SIGNATURE IS A CONFIRMATION OF THE ACCURACY OF THE TRANSCRIPTION OF THE INFORMATION BY THE CHA.**

**( ) THE NOTICE OF REASONABLE ACCOMMODATIONS FOR ALL TENANTS HAS BEEN RECEIVED AND READ BY THE TENANT AND OR EXPLAINED TO THE TENANT BY CHA PERSONNEL**

**NOTE: ALL INFORMATION PROVIDED ON THIS FORM IS SUBJECT TO VERIFICATION BY CHA PERSONNEL**

**I DO HEREBY SWEAR AND ATTEST THAT ALL THE INFORMATION PROVIDED ON THIS APPLICATION IS TRUE AND CORRECT. I UNDERSTAND THAT I MUST REPORT ANY CHANGES IN INCOME, ASSETS, AND FAMILY COMPOSITION TO THE HOUSING AUTHORITY OF THE CITY OF CHARLESTON IN WRITING WITHIN TEN (10) WORKING DAYS OF SUCH CHANGE. I FURTHER UNDERSTAND THAT FALSE STATEMENTS OR INFORMATION PROVIDED ARE PUNISHABLE UNDER FEDERAL AND STATE LAW AND CONSTITUTE GROUNDS FOR TERMINATION OF MY HOUSING ASSISTANCE. FINALLY, I UNDERSTAND THAT 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 STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.**

\_\_\_\_\_  
**Signature of Head of Household**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Spouse of Head of Household**

\_\_\_\_\_  
**Date**

**(IF YOU BELIEVE THAT YOU HAVE BEEN DISCRIMINATED AGAINST, YOU MAY CALL THE FAIR HOUSING & EQUAL OPPORTUNITY NATIONAL TOLL-FREE HOT LINE AT 1-800-669-9777)**



