ESTE DOCUMENTO ES IMPORTANTE. POR FAVOR BUSQUE QUIEN SE LO TRADUZCA.

SECTION 8 VOUCHER PROGRAM
FORM FOR CONTINUED OCCUPANCY

NAME_____

CURRENT ADDRESS_____APT #_____

CITY, STATE, ZIP CODE_____

PHONE #_____HEAD WORK #_____SPOUSE WORK #_____

CELL: _____ Email: _____

HOUSEHOLD COMPOSITION AND CHARACTERISTICS

List the Head of Household and all other members who will be living in the assisted unit. Give the relationship of each family member to the Head.

Member's Full Name	Relationship	Birth Date	Age	Sex	Social Security Number	Full-Time Student Yes/No

EMPLOYMENT AND INCOME: List **all** household members who are working or receiving any sources of income including but not limited to: **PENSIONS, SOCIAL SECURITY, SSI, TAFDC, CHILD SUPPORT, BUSINESS WAGES, COMISSIONS, TIPS, ANNUITIES, ALIMONY, UNEMPLYOMENT, COMPENSATION, OTHER NON-WAGE SOURCES OR ANY FINANCIAL ASSISTANCE.**

Family Member	Source of Income/ Type of Income	Actual Income
		$
		$
		$
		$
		$
		$

ASSET INFORMATION

List all checking and savings accounts (including IRA'S, Keough accounts, and Certificates of Deposit) of all household members, including amounts disposed of during the last two (2) years.

Family Member	Bank Name/Address	Account Number	Amount

Do you receive food stamps? ☐ Yes ☐ No If Yes: $_____

List the value of all stocks, bonds, trusts, pension's contributions, or other assets: $_____
Do you own a home or other real estate? ☐ Yes ☐ No

Have you sold or given away real property or other assets in the past two (2) years? ☐ Yes ☐ No
If yes, what is the current market value of the asset? $_____

EXPENSES

Do you pay for childcare which enables you or another family member to work or attend school?
IF yes, please complete the CHILD Care Verification Form. ☐ Yes ☐ No

MEDICAL INSURANCE (Elderly and Disabled Families Only)
Do you pay for any medical insurance? ☐ Yes ☐ No
If yes, list the name and address of insurance company and monthly cost.
_____ $_____ _____

_____ $_____

DISABLED/HANDICAPPED FAMILIES ONLY
Do you pay for a care attendant or for any equipment for the handicapped member(s) of the family necessary to permit that person or someone else in the family to work? ☐ Yes ☐ No
If yes, describe expenses_____

_____

Do you have Medicare? ☐ Yes ☐ No

If yes, what is your Medicare premium? $_____

Do you pay for prescriptions which are not covered by insurance? Yes ☐ No ☐
If yes, please contact your pharmacy(s) and request a print out of prescriptions you purchased for the year.

List the names, addresses and phone numbers of two relatives or friends who generally know how to contact you

1. Name: _____
   Address: _____
   _____
   Phone #: _____

2. Name:_____
   Address: _____
   _____
   Phone #: _____

Are you or any member of your household subject to a lifetime registration requirement under a state sex offender registration program? Yes ☐ No ☐

APPLICANT CERTIFICATION: I/we certify that the information given to the Salem Housing Authority on household composition, income, net family assets, allowances, and deductions is accurate and complete to the best of my/our knowledge and belief. I/we understand that false statements or information are grounds for termination of housing assistance.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

Signature of Head_____ Date
Signature of Spouse_____ Date
Signature of Other Adult_____ Date

Signature of Other Adult_____ Date
Signature of Other Adult_____ Date
Signature of Other Adult_____ Date