**Housing Authority/City of Washburn and County of Bayfield**

**420 East Third Street, Washburn, WI 54891**

**Telephone: 715-373-2653 ext. 11 Fax: 715-373-2610**

**"This institution is an equal opportunity provider"**

**AUTHORIZATION FORM**

To Whom It May Concern:

I hereby grant the Housing Authority of the City of Washburn and County of Bayfield permission to secure any information concerning my income, assets, deductions, or the release of other information stated below. I understand that this information will be kept strictly confidential and will be used only to determine my rent, initial and continued eligibility or be used to administer and enforce program rules and policies.

|  |
| --- |
| Name:       |
|  |  |  |  |  |  |  |  |  |
| Signature: | x |     |  | Date: x |    |
|  |  |  |  |  |  |  |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Co-Tenant Signature  | Date:x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
|  |  |

**Authorized Information which may be requested includes:**

Child Care Expenses

Employment Income

SSI Income

Disabled Assistance Expenses

Social Security Numbers

Welfare

Utility Payments

Maintenance Income

Credit History

Pension Income

Federal, State or Local Benefits

Residences and Rental History

Medical Insurance Expenses

Unemployment Income

Criminal Activity

Asset Income

Identity and Marital Status

Family Composition

Social Security Income

Medical Expenses

TANF Income

Medicine Expenses

Child Support Income

**Family Composition Form**

I certify that these are the persons (including myself) who are currently residing at

Mailing Address (if different from above):

**NAME BIRTHDATE SOCIAL SECURITY #**

**Phone Number:**  Or message phone number:

**Email:**

**Name, Address and phone number of a person to contact in case of an emergency:**

Is anyone in your household a full-time student? [ ]  Yes [ ]  No

**Fill out this portion if anyone in your household is a student**

Student Information:

List all household members that are students:

Member:       School:       Full/Part-time?

Member:       School:       Full/Part-time?

Member:       School:       Full/Part-time?

**If ALL members are full time students, complete the following yes/no questions:**

[ ]  Yes [ ]  No Are you married and filing a joint tax return? Please attach a signed copy of tax return.

[ ]  Yes [ ]  No Are you receiving W-2 or TANF?

[ ]  Yes [ ]  No Are you enrolled in a Job Training Partnership Act (JTPA) or similar county or state program?

[ ]  Yes [ ]  No Are you a single parent with child(ren) and neither you nor the child(ren) are dependants on someone else's tax return? Please attach a signed copy of tax return.

The above is a true and accurate account of those living with me at the present time. If I am living alone in the rental unit, only my information is included above.

I am aware that any fraud in connection with federally subsidized rental units is a criminal offense under federal and state law.

Having persons living in a federally subsidized unit who are not on the lease for that unit does having persons living in a federally subsidized unit who are not on the lease for that unit does

 Tenant's Signature Co-Tenant's Signature, if any

 Other Adult's Signature Date

**Declaration of Income/Assets/Deductions**

**If you answer "yes" to any question on this form, be sure to complete the entire section.**

**Note:** The term "household" refers to all persons who live or will be living in the rental unit.

**If you need more space to complete any section, you can attach your added information.**

**INCOME**

**Pension Income:** Does anyone in your household have pension income? [ ]  Yes [ ]  No

If yes, state monthly amount: $      Account#      Who receives the pension?

Name and address of pension source:

**Social Security Income:** Does anyone in your household have Social Security income? [ ]  Yes [ ]  No

If yes, state monthly **gross** amount: $      Who receives this

Is Medicare deducted?:[ ]  Yes[ ]  No ; SS# under which this income is received:

***PLEASE SUPPLY US WITH A CURRENT COPY OF YOUR SOCIAL SECURITY LETTER STATING THE AMOUNT OF YOUR NEW BENEFITS AND DEDUCTIONS***

**SSI Income:** Does anyone in your household have SSI income? [ ]  Yes [ ]  No

If yes, state monthly amount: $      Who receives this

SS# under which this income is received:

**Employment Income.** Does anyone in your household receive employment income? [ ]  Yes [ ]  No

If yes, state monthly **gross** amount: $     Who receives this

State name & address of employer:

**Child Support Income.** Does anyone in your household receive child support income? [ ]  Yes [ ]  No

If yes, state average monthly child support income:$     Who receives this

Name and address of Child Support Agency

If you are **NOT** actively pursuing child support, list the reason why

***ALSO WE ARE NOW REQUIRING YOU TO PROVIDE US WITH A COPY OF YOUR CURRENT CHILD SUPPORT COURT ORDER****.*

**Unemployment Income.** Does anyone in your household have unemployment income? [ ]  Yes [ ]  No

If yes, state the average **weekly** amount: $     Who receives this

**Any Other Income.** Does anyone in your household receive any other income from any other source?[ ]  Yes [ ]  No

If yes, state monthly amount: $      Who receives this

Do you receive food stamps? [ ]  Yes [ ]  No If yes, please state monthly amount: $

Do you anticipate earning income in the coming year? [ ]  Yes[ ]  No; If so, from what source:

Amount of anticipated earnings per hour $     ; anticipated hours per week:

**ASSET INCOME**

**Checking Account:** Does anyone in your household have a checking account? [ ]  Yes [ ]  No

If yes, who has this/these account(s)?

State Name(s)/Address of bank(s)

**Savings, CD, MMC, other savings accounts (IRA’s, Bonds, etc.)**. Does anyone in your household have any of the above accounts or any other types of asset accounts? [ ] Yes [ ]  No

If yes, who has this/these account(s)?

State Name(s)/Address of bank(s)

**Home/Property.** Does anyone in your household own land or a home? [ ]  Yes [ ]  No

If so, who owns the land/property?

**Enclose a copy of the last tax statement, showing the fair market value of the property.**

**CHILD CARE EXPENSES**

Does anyone in your household have child care expenses that enable that person to work or go to school? [ ] Yes [ ]  No. If yes, who?       Are the expenses reimbursed? [ ] Yes [ ] No If yes, state amount reimbursed:$     By Whom:

State name/address of child care provide:

**Complete (if applicable) and sign second page as well**

**MEDICAL EXPENSES**

*If your family head or co-head is under 62 and is not a person living with disabilities, skip the section below and sign this form at the bottom. If your family head or co-head is 62+ or a person living with disabilities, complete the section below thoroughly before signing this form. Incomplete information could result in fewer deductions used to calculate your rent.*

**Prescription Expenses.** Does anyone in your household have regular prescription expenses that are NOT reimbursed by any source?[ ]  Yes [ ]  No. **State names and addresses of pharmacy/pharmacies:**

Are any portions of the prescriptions paid by your insurance or another source? [ ]  Yes [ ]  No

If yes, what percent is paid after what deductible amount?      % after $      deductible amount

**Over the Counter Medical Expenses:** Does anyone in your household have regular over-the- counter expenses? [ ]  Yes [ ]  No If yes, complete the section below for each expense

**Name Price How Long Purchase Lasts For Which Family Member**

***Note:*** *We cannot use over-counter expenses unless you provide us with:* ***1.*** *Proof from doctor (in the form of a prescription, letter, etc.) saying that the above is needed for a medical condition;* ***2****. Proof of cost, in the form of receipts for each and every purchase.*

**Health Insurance Expense.** Does anyone in your household have health insurance for which you have to pay a premium? [ ]  Yes [ ]  No. If yes, who?      Policy number:      Amount paid: $

per (circle one): month every-other month quarter 1/2 yr year

Name & address of insurance company:

**Doctor's, Dentist's, Eye Doctor's Expenses.** Does anyone in your household have regular doctor's, dentist's, or eye doctor's expenses NOT reimbursed by any source? [ ]  Yes [ ]  No If yes, complete the section below for each Clinic, hospital or other source that you go to.

**Clinic/Hospital/Other Address For Which Family Member**

**Mileage Expense:** Does anyone in your household have to pay someone to bring that person to the doctor? [ ]  Yes [ ]  No If yes, state the amount paid per trip: $     How many trips per year?

Name of medical facility and location

Do you get reimbursed for these payments? [ ]  Yes [ ]  No

Does anyone in your household have to drive himself/herself to the doctor? [ ]  Yes [ ]  No

 Name of Doctor, Name of Clinic and Location:

**Outstanding Medical Expenses.** Does anyone in your household have any large medical expenses on which monthly payments are being made? [ ]  Yes [ ]  No. If so, list the medical facility that you make these payments to?

**I do hereby swear and attest that all information contained on this form is true and correct. I also understand that all changes in income as well as any changes in household members must be reported to the Housing Authority Occupancy Specialist immediately.**

 Head of Household Signature Co-Tenant's Signature, if any

Other Adult's Signature Date