HOUSING AUTHORITY OF FORT MILL
PO Box 220 * Fort Mill, SC 29716-0220
Phone: 803-547-6787 TDD/Fax: 803-548-2125

Personal Declaration - Reexamination

INSTRUCTIONS:
YOU MUST COMPLETE THIS FORM AND BRING IT TO YOUR OFFICE APPOINTMENT. (Please Print or Type in Ink) THIS FORM MUST BE SIGNED BY ALL ADULTS.

The information you give regarding household composition, income, family assets and deductions must be accurate and complete to the best of your knowledge and belief

*Current Phone Number*_____ *Email Address* _____

A. HOUSEHOLD ADULT MEMBERS: (List children in Part B.)

List yourself and all other persons who are part of your household. List all adults, age 18 and over in this section. Print clearly. This section is for adults only.

1. Head of Household
Full Name _____Social Security #_____

Birth Place/City, State_____ Birthdate _____ Driver's License/ID # _____

2.
Full Name _____Social Security #_____

Birth Place/City, State_____ Birthdate _____ Driver's License/ID # _____

3.
Full Name _____Social Security #_____

Birth Place/City, State_____ Birthdate _____ Driver's License/ID # _____

4.
Full Name _____Social Security #_____

Birth Place/City, State_____ Birthdate _____ Driver's License/ID # _____

B. CHILDREN IN HOUSEHOLD: List all children in your household (under 18 years of age).

1.
Last Name _____ First Name_____ MI ____

Relation to Head of Household:

Social Security #_____ Sex_____ Birth Date_____

Birth Place _____ School Name _____

Parent's Names _____

2.
Last Name _____ First Name_____ MI ____

Relation to Head of Household:

Social Security #_____ Sex_____ Birth Date_____

Birth Place _____ School Name _____

Parent's Names _____

Relation to Head of Household:

3.
Last Name _____ First Name_____ MI ____

Social Security #_____ Sex_____ Birth Date_____

Birth Place _____ School Name _____

Parent's Names _____

4.
Last Name _____ First Name_____ MI ____

Relation to Head of Household:

Social Security #_____ Sex_____ Birth Date_____

Birth Place _____ School Name _____

Parent's Names _____

C. FOSTER CHILDREN:
Is anyone living in your home a foster child? ____ Yes ____ No
If yes, list complete name, birth date and social security number for each foster child:

_____

D. LIST ALL FULL-TIME STUDENTS 18 YEARS OR OLDER:

_____
Student's Name Name and Address of School

_____
Student's Name Name and Address of School

_____
Student's Name Name and Address of School

E. WORKING: Is anyone working, expecting to work in the next 6 months, or change employment in the next year?

If yes, complete the portion below. (If self-employed, please provide a ledger of income And expenses.)

Name _____Occupation _____ Gross Wage Per Month _____

Employer's Name _____ Phone _____ Fax _____

Employer's Address _____ City, State, Zip Code _____

Do you ever receive any of the following?
Overtime ____Yes ____ No Tips ____ Yes ____ No

Bonus ____ Yes ____ No Commission ____ Yes ____ No

_____

Name _____ Occupation _____ Gross Wage Per Month _____

Employer's Name _____ Phone _____ Fax _____

Employer's Address _____ City, State, Zip Code _____

Do you ever receive any of the following?

Overtime ____Yes ____ No Tips ____ Yes ____ No

Bonus ____ Yes ____ No Commission ____ Yes ____ No

Name _____ Occupation _____ Gross Wage Per Month _____

Employer's Name _____ Phone _____ Fax _____

Employer's Address _____ City, State, Zip Code _____

Do you ever receive any of the following?

Overtime ____Yes ____ No Tips ____ Yes ____ No

Bonus ____ Yes ____ No Commission ____ Yes ____ No

F. INCOME: Does anyone, including children, receive or expect to receive money from any source listed below? Check "Yes" or "No" for each item. If yes, list who and amount received monthly>

Item	*Yes*	*No*	*Who*	*Monthly Amount*
• Training	____	____	_____	_____
• Work Study	____	____	_____	_____
• Educational Loans	____	____	_____	_____
• Grants, Scholarships	____	____	_____	_____
• TANF	____	____	_____	_____
• Food Stamps	____	____	_____	_____
• General Relief	____	____	_____	_____
• Unemployment Benefits	____	____	_____	_____
• State Disability	____	____	_____	_____
• Workers Compensations	____	____	_____	_____
• Child Support	____	____	_____	_____
• Spousal Support	____	____	_____	_____
• Social Security	____	____	_____	_____
• SSI	____	____	_____	_____
• Pension/Retirement	____	____	_____	_____
• Veteran's Benefit	____	____	_____	_____
• Military Allotment	____	____	_____	_____
• Railroad Retirement	____	____	_____	_____
• Interest/Asset	____	____	_____	_____
• Income from Rental Prop.	____	____	_____	_____
• Second Job	____	____	_____	_____
• Other; Explain:	____	____	_____	_____

_____

_____

_____

_____

TANF or GR _____
Worker Name Number DSS Office Address City, State, Zip Phone

TANF or GR _____
Worker Name Number DSS Office Address City, State, Zip Phone

Bring your most recent proof of income and your last Federal Income Tax Return to your office appointment (examples: letter from employer, check stubs, welfare or social security award letters, bank statements, 1099 forms, etc.).

G. Does anyone, including children, have any of the following resources? Check Yes or No For each item. If yes, list who and amount.

Item	Yes	No	Who	Amount
• Cash	____	____		
• Checking Account(s)	____	____		
How many Checking Accounts do you have:	____			
• Savings Account(s)	____	____		
How many Savings Accounts do you have?	____			
• Life Insurance Policy	____	____		
• Trust Funds	____	____		
• Stocks or Bonds	____	____		
• Certificates of Deposit or Money Market Account	____	____		
• Notes, Mortgages, or Deeds	____	____		
• Retirement Accounts	____	____		
• Deferred Compensation	____	____		
• Safe Deposit Box	____	____		
• Real Estate	____	____		
• Other, Explain:	____	____		

If yes to any items above, complete the following:

Type of Resource	Current Value	Name and Address of Institution	Account Number

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H .Do you employ the services of a Care Provider for a child 12 years or under or for a person? ____ Yes ____ No

If yes, complete the following:

1)Care Provider Name _____ Amount Paid Weekly _____

Care Provider Address _____ Phone _____

2)Care Provider Name _____ Amount Paid Weekly _____

Care Provider Address _____ Phone _____

If your care provider is not a licensed state provider then you must also provide money order copies that have been completed to the provider or proof of payment by your bank statement showing checks that have been applied toward your account.

I. Does anyone receive contributions, gifts or loans from any source? ____ *Yes* ____ *No*
If yes, complete the following:

Item Received	Value of Item	Who Gives the Item

J. Does anyone own or is anyone buying real estate, such as land and/or buildings, mobile homes, etc., anywhere?
____ Yes ____ No If yes, complete the following:

Type	Address	Estimated Value

K. Does anyone receive any income from any other source, including someone outside your household paying for any of your bills or giving you money? ____ Yes ____ No

If yes, please explain:

L. Does anyone own or have the use of any vehicle, such as car, truck, motor home, motorcycle, off-road vehicle, camper, boat, or any other type of vehicle? ____ Yes ____ No
If yes, complete the following:

Type	License Tag #	State	Year	Make and Model

M. Do you have a live-in aide? ____ Yes ____ No If yes, please complete the following:

Name Social Security #
Do you pay for this service yourself? ____ Yes ____ No If no, please explain:

N. Have you or any member of your household (listed above) ever been arrested for any drug related criminal activity since move in or last reexamination?
____ Yes ____ No If yes, please give dates, charges, city and state:

O. Have you or any member of your household (listed above) ever been arrested for any felonious violent criminal that has as one of its elements the use, attempted use, or threatened use of physical force against a person or property of another since move in or last reexamination? ____ Yes ____ No
If yes, please give dates, charges, and city and state:

P. Has anyone on this application ever been arrested or detained by the police for a crime (other than traffic violations) since move in or last reexamination? Yes ____ No ____ If yes, please give dates, charges, city & state

Q. Are you or any member of your household subject to a lifetime sex offender registration requirement in any state?
____ Yes _____No If yes, what state_____

R. Have you or any other adult member ever used any name(s)/social security number(s) other than the one you have listed? ____ Yes ____ No

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S. Have you or any other adult household member sold any business or asset in the last 2 years for less than its full value? ____ Yes ____ No If yes, explain:

_____

_____

T. MEDICAL EXPENSES – ELDERLY OR DISABLED FAMILIES ONLY

If the head of household or the spouse of the head of household is: a) 62 years of age or older; b) A family whose head, spouse, or sole member is a person with disabilities; two or more persons with disabilities living together; or one or more persons with disabilities living with one or more live-in aides; or c) ; AND if any household member pays for medications, medical/dental treatments, medical insurance, or prescribed appliances which are not reimbursed, bring in verification of monthly/yearly costs. You may bring receipts for medicine or a statement from your pharmacist itemizing the medications and cost. Be sure to bring your medicare and insurance statements with you.

Name of Pharmacy	Address	City, State, Zip
Name of Pharmacy	Address	City, State, Zip
Name of Doctor or Medical Facility	Address	City, State, Zip
Name of Doctor or Medical Facility	Address	City, State, Zip

CURRENT HOUSEHOLD EXPENSES (Estimated monthly, <u>if you do not have please put $0.00</u>)

Electric_____ Telephone_____ Auto_____ Auto Insurance_____
Gas _____ Medical _____ Loans_____ Credit Cards _____
Water _____ Health Ins. _____ Life Ins._____ Child Care _____
Cable _____ Furniture _____

EMERGENCY CONTACTS:

Name	Relationship	Phone #	Address
Name	Relationship	Phone #	Address

APPLICANT/TENANT CERTIFICATION & NOTICE

I/We certify that the information* given to the Housing Authority on household composition, income, net family assets and 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 punishable under Federal law. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

*After verification by this PHA, the information will be submitted to HUD on Form HUD-50058 (Tenant Data Summary, a computer-generated facsimile of the form or on magnetic tape. See the Federal Privacy Act Notice for more information about its use.)

WARNING! 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 FRADULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.

I do hereby swear and attest that all the information above about me and my household is true and correct. I also understand that all changes in household members or income must be reported to the Public Housing Authority ***IN WRITING*** immediately (no later than 14 days of the occurrence).

I declare under penalty of perjury under the laws of the United States of America and the State of South Carolina that the information contained in this statement of facts is true, correct, and complete.

Signature of Head of Household	Date	Signature of Head of Household	Date
Signature of Other Adult	Date	Signature of Other Adult	Date

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The Housing Authority of Fort Mill enforces the Violence Against Women Act (VAWA) Policy. The policy has some of the following goals and objectives:

- To ensure the physical safety of victims of actual or threatened domestic violence, dating violence or stalking who are assisted by the Housing Authority of Fort Mill with the victims cooperation and assistance.
- Provide and maintain housing opportunities for victims of domestic violence, dating violence or stalking
- Create and work to maintain collaborative arrangements between law enforcement, victim service providers and others to promote the safety and well-being of victims of actual and threatened domestic violence, dating violence and stalking
- To take appropriate action in response to an incident or incidents of domestic violence, dating violence, or stalking

This policy is also gender-neutral, and its protections are available to males as well as females. This information must be provided by the victim on a HUD certified form. All information (including the fact that an individual is a victim of domestic violence, dating violence or stalking) provided to the Housing Authority or to Section 8 owner or manager shall be retained in confidence and shall not be entered in any shared database nor provided to any related entity except where requested by the victim in writing, required for a public housing eviction or Section 8 assistance as permitted by policy or required by the law.