



Housing Authority
of the County of Stanislaus

(209) 557-2000
P.O. Box 581918
1701 Robertson Rd.
Modesto, CA 95358-0033
www.stancoha.org

SECTION 8 CHANGE REPORT
Applicant on the Wait List

TENANT NAME: _____ SS#: _____

WANT TO REPORT A CHANGE? THEN COMPLETE THIS FORM. PLEASE FILL OUT ONLY THOSE AREAS WHICH APPLY TO YOUR CHANGE OR CHANGES. Your help is essential in recording the proper information. Please check the category of change which applies to you, there may be more than one.

MARK THE NUMBER(S) BELOW AND PROVIDE THE INFORMATION OR DOCUMENTS REQUESTED. PLEASE NOTE THE DOCUMENT AND INFORMATION BEING ASKED FOR IN THE FOLLOWING STATEMENTS:

ARE YOU A FAMILY SELF SUFFICIENCY PARTICIPANT? Yes _____ No _____

1. () **ADDING MEMBER(S) TO FAMILY:** a. Provide a BIRTH CERTIFICATE; b. a MARRIAGE LICENSE if the change is adding a SPOUSE; c. If an adult, 18 years old and older, provide proof of EMPLOYMENT or BENEFITS being received by the NEW PERSON; d. Proof of SOCIAL SECURITY NUMBER; e. Written Landlord permission letter; f. Effective DATE OF CHANGE _____.
2. () **DELETE FAMILY MEMBER(S):** a. Provide NAME, SOCIAL SECURITY NUMBER, NEW ADDRESS, COPY OF RENT RECEIPT & LEASE of Adult Member leaving the home-- Name & Social Security Number only for minors leaving the home; b. Has INCOME changed as a result of Member leaving? If so, provide verification; c. Effective DATE OF CHANGE _____.
3. () **INCOME OR BENEFIT CHANGE:** a. Provide proof of INCOME or BENEFIT change; **WHAT IS YOUR CURRENT GROSS MONTHLY INCOME AMOUNT NOW?** _____
4. () **TELEPHONE ADD/DELETE:**
NEW TELEPHONE NUMBER (give number) () _____ - _____
NEW MESSAGE TELEPHONE (give number) () _____ - _____
5. () **OTHER TYPE OF CHANGE:** Please specify the type of change to be made that is not listed above in the COMMENTS SECTION below.

COMMENTS: Please explain the change, (PLEASE PRINT):

THIS FORM MUST BE RETURNED TO THE HOUSING AUTHORITY'S SECTION 8 DEPARTMENT FOR REVIEW. ONCE YOUR CHANGE REPORT IS RECEIVED AND REVIEWED, YOU WILL BE NOTIFIED BY MAIL WITHIN 30 DAYS FROM THE DATE WE RECEIVED THIS FORM WHETHER AN APPOINTMENT IS NECESSARY. IF YOU DO NOT RECEIVE A RESPONSE WITHIN 30 DAYS, PLEASE CONTACT THIS OFFICE.

(Print Name)

(Address)

(Telephone Number)
WP Form 169;sm, 10/03

(Sign Name)

(City) (Zip Code)

(Date)

HOUSING AUTHORITY OF THE COUNTY OF STANISLAUS

APPLICANT / PARTICIPANT QUESTIONNAIRE

HOUSEHOLD INFORMATION & INCOME SOURCES: List all persons who are currently living in your home (including yourself). If you are an applicant, list only those who will be living with you under the Housing Choice Voucher Program.

| Household Members Name, Social Security # and Date of Birth | Relation to Head of Household | Source / Type of Income | Gross Monthly Income |
|--|----------------------------------|----------------------------|-------------------------|
| 1. (Head) Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 2. (Co-Head) Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 3. Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 4. Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 5. Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 6. Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 7. Name: _____ SS# : _____ Date of Birth: _____ | | | |
| 8. Name: _____ SS# : _____ Date of Birth: _____ | | | |

NOTE: If more space is needed list additional family members and/or income on a separate sheet of paper.

Address: _____ Zip: _____ Phone: Hm _____ Wk _____ Ms _____
 Emergency Contact Name: _____ Phone: _____ Relationship: _____
 Head of Household Marital Status: Never Married _____ Married _____ Separated _____ Widowed _____ Divorced _____

ABSENT PARENT(S)

Name: _____ Address: _____ DOB: _____ SSN: _____
 Name: _____ Address: _____ DOB: _____ SSN: _____

Have you or any other family member ever used any name(s) or Social Security number(s) other than the one you are currently using?

Yes _____ No _____ If yes, list name(s) and SS#(s): _____

The primary language of the Head of Household is: English _____ Spanish _____ Chinese _____ Vietnamese _____ Farsi _____ Other _____

PRIOR HOUSING ASSISTANCE RECEIVED

Have you or anyone in the household ever been terminated or evicted from any Federally Subsidized Housing Program? Y _____ N _____

Name/Address of unit: _____

Does anyone in your household owe money to any Housing Authority? Yes _____ No _____

CRIMINAL HISTORY As an adult, have you or any member of your household ever been arrested for drug-related offenses, acts of physical violence to persons or property, sex offenses or any other type of arrests? Y _____ N _____. If yes, identify person and list each offense, date, place (City/State), court and action taken (attach an additional sheet if more space is needed)

INCOME INFORMATION

ARE YOU OR IS ANYONE IN YOUR HOUSEHOLD:

YES NO

| | | |
|--|--|--|
| 1.) Currently employed, or have worked anywhere in the past 12 months? List: _____ | | |
| 2.) Expecting to work in the next 12 months? | | |
| 3.) On leave of absence from work due to lay-off, medical or military leave? | | |
| 4.) Receiving or expecting to receive unemployment benefits or disability benefits in the next 12 months? | | |
| 5.) Receiving, expecting to receive or entitled to alimony or child support? | | |
| 6.) Receiving, expecting to receive or entitled to veteran benefits? | | |
| 7.) Receiving, expecting to receive or entitled to workers compensation insurance benefits? | | |
| 8.) Receiving or expecting to receive welfare assistance (AFDC/GA)? | | |
| 9.) Receiving or expecting to receive Social Security benefits (including SSI)? | | |
| 10.) Receiving or expecting to receive income from a pension, annuities or an accident insurance benefits? | | |
| 11.) Receiving cash contributions from individuals not living in the unit or from other agencies? | | |
| 12.) The owner of life insurance or burial policies? | | |
| 13.) Receiving or expecting to receive a scholarship or grant to go to school or job training? | | |
| 14.) Receiving or expecting to receive any other source of income? Explain: _____ | | |
| 15.) Expecting anyone to move in or out of the household? Name: _____ Relationship: _____ When: _____ | | |

ASSET INFORMATION

DOES ANYONE IN THE HOUSEHOLD HAVE ANY ASSEST LISTED BELOW?

Include all assets owned, used, controlled, shared or held jointly with or for another person(s).

| | | | | | |
|---|-----|----|------------------------------------|-----|----|
| 1.) Checking Account | Yes | No | 6.) Mortgages / Deeds / Notes | Yes | No |
| 2.) Savings / Credit Union Account | Yes | No | 7.) Retirement Funds | Yes | No |
| 3.) Trust Funds / Life or Burial Insurance | Yes | No | 8.) IRA / Keough Plans/ etc. | Yes | No |
| 4.) Stocks / Bonds / Certificates of Deposit / Money Market Accounts / etc. | Yes | No | 9.) Employee Deferred Compensation | Yes | No |
| 5.) Real Estate/Rental Property | Yes | No | 10.) Other: Explain | Yes | No |

If you answered Yes to any items listed above, make sure to complete the following items below:

| Type of Asset | Family Members Name | Current Value | Amount Owed (if any) | Name & Address of Bank / Other | Account / Policy Number |
|---------------|---------------------|---------------|----------------------|--------------------------------|-------------------------|
| | | \$ | \$ | | |
| | | \$ | \$ | | |
| | | \$ | \$ | | |
| | | \$ | \$ | | |

List all vehicles registered AT YOUR ADDRESS, include license plate number(s): _____

List all vehicles belonging to household members, include license plate number(s): _____

Have you sold or given away real property or other assets in the past two years? Yes _____ No _____

If Yes, what is the current market value of the assets? _____

EXPENSES

Do you pay for child care which enables you or another family member to work or go to school? Yes _____ No _____

If Yes, give name and address of child care provider, weekly cost and name of working family member(s): _____

Is anyone in the household a full-time student over the age of 18 yrs? Yes _____ No _____

FAMILIES WITH DISABILITIES (Head or Spouse is permanently disabled or handicapped)

Do you pay for a care attendant or for any equipment for the disabled member(s) of the family necessary to permit that person or someone else in the family to work? Yes _____ No _____ If Yes, describe the expenses: _____

ELDERLY / DISABLED FAMILIES ONLY (Head or Spouse must be a least 62 years of age or permanently disabled or handicapped)

Do you have Medicare? Yes _____ No _____ If Yes, what is your Medicare premium? \$ _____

Do you have any other kind of medical insurance? Yes _____ No _____ If Yes, give policy number and agent's name: _____
Medical insurance premium that you pay is \$ _____ Monthly.

Do you receive Medi-Cal? Yes _____ No _____

Do you have any outstanding medical bills on which you are paying that are not covered by medical insurance? Yes _____ No _____

Do you expect to have any medical expenses during the next 12 months that are not covered by medical insurance? Yes _____ No _____

APPLICANT / TENANT RENTAL INFORMATION

I pay \$ _____ per month for rent to the landlord. (I understand that I cannot pay more than what is stated on the Lease.)

I pay for Gas: Yes _____ No _____ Electricity: Yes _____ No _____ Water: Yes _____ No _____ Garbage: Yes _____ No _____

The refrigerator in the unit is mine: Yes _____ No _____ The stove in the unit is mine: Yes _____ No _____

TENANT OBLIGATION: I MUST NOTIFY THE STANISLAUS COUNTY HOUSING AUTHORITY OF ALL INCOME (INCLUDING PUMP SUM PAYMENTS) AND HOUSEHOLD MEMBER CHANGES IN WRITING WITHIN 30 DAYS OF THE CHANGE. I UNDERSTAND THAT FAILURE TO DO SO COULD RESULT IN REPAYMENT OF RENTAL SUBSIDIES OVERPAID ON MY BEHALF.

APPLICANT / PARTICIPANT CERTIFICATION: I/WE CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM 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, TITLE 18, SECTION 1001 OF THE UNITED STATES CODE. I/WE UNDERSTAND THAT FALSE STATEMENTS OR INACCURATE AND/OR OMITTED INFORMATION ARE GROUNDS FOR TERMINATION AND/OR DENIAL OF HOUSING ASSISTANCE AND TERMINATION OF TENANCY.

Signature of Head: _____ Date: _____

Signature of Spouse/Partner: _____ Date: _____

Signature of Family Member: _____ Date: _____

Signature of Family Member: _____ Date: _____

Signature of Family Member: _____ Date: _____

Name of Interpreter: _____ Phone Number: _____

Signature of Interpreter: _____ Date: _____