

Public Housing Recertification Packet Instructions

****Please read carefully****

The United States Department of Housing and Urban Development (HUD) requires that the income, assets, and expenses that Public Housing tenants report must be verified directly from the source without the tenant's assistance or interference. This means that the MHC cannot alone accept documentation that you provide. Instead, we must fax, mail, or telephone the source to obtain the necessary information. If after several attempts we are unable to obtain the information directly from the third-party source, we may accept your tenant-provided documentation as verification.

Therefore, in the pages that follow, it is imperative that you provide ALL of the contact information (phone and fax numbers, mailing addresses, names of persons to contact) for each of the items that apply to your household (incomes, assets, expenses). **If you do not know all of the contact information, the burden is on you to find and include it. Please ensure that you pinpoint the exact department and/or person who is responsible for verifying the information (i.e. Human Resources/Payroll Clerk, Patient Billing Specialist, etc.). I am no longer able to do the researching for you.**

IMPORTANT: Failure to attend appointments, provide complete contact information for income, asset, etc. verification, respond to MHC requests in a timely manner, and/or provide required signatures can each delay the completion of your recertification process. Being uncooperative or impeding the recertification process is a serious violation of your Dwelling Lease Agreement and could result in changing your rent amount to the current flat-rent amount and/or your eviction from Public Housing. (Part II, Section II states in part, "...Failure to provide required information may result in a rent increase to Flat Rent until recertification is completed and/or an eviction from the unit is processed...")

Following these instructions will make the annual recertification process easier and quicker for you and for the MHC. Your cooperation is appreciated!

***Persons with disabilities may request a reasonable accommodation in order to comply with the terms set forth by the Marquette Housing Commission.**

FRAUD DEFINED

Fraud is a criminal act that involves theft of taxpayers' monies from HUD's Programs. Examples of fraud include but are not limited to:

- Making false or misrepresentative statements as an applicant or program participant, verbally or in writing, regarding household income, assets, family composition/family size, expenses, or assets.
- Intentionally or unintentionally omitting, concealing, or failing to report within the time period outlined in MHC policy, any information that would have resulted in a decrease of the amount of subsidy the family qualified for, or that would have resulted in the family being ineligible for admission into an MHC housing assistance Program.
- Destroying or concealing records
- Forging or altering documents
- Theft
- Abuse of any kind of an MHC housing assistance Program

Fraud may be *punishable* any of the following ways:

- Termination from Public Housing or the Housing Choice Voucher Program
- Mandatory repayment of subsidy overpayments issued
- Referral to a collection agency
- Legal prosecution
- Referral to the United States Department of Housing and Urban Development (HUD) Office of the Inspector General (OIG) for investigation and possible federal prosecution
- Ineligibility for participation in future housing assistance programs

Fraud may be *prevented* in the following ways:

- **Be truthful and forthcoming** when reporting information to the MHC
- **Pay attention to detail** when reporting information and when reading MHC paperwork
- **Be diligent** in knowing what is required while you are a program participant
- **Read everything carefully** and understand all the material before signing anything
- **Ask questions when uncertain**
- **Don't rely on other (unofficial) sources** for program requirement info. (friends, neighbors, etc.)
- **Become familiar with MHC Policies and procedures** by reading MHC-issued newsletters, Notices, Program Contracts, and attending MHC informational meetings as scheduled
- **Notify the MHC** if you require additional assistance, or, for persons with disabilities, if you would like to request a reasonable accommodation in order to comply with Program requirements

Tenant Certification

I understand what constitutes fraud as defined by the Marquette Housing Commission. MHC staff has discussed this form with me and elaborated on the types of fraud and how it relates to assisted housing programs. A copy of this document has been provided to me for my records.

Printed Name of Head of Household

Signature

Date

Signature- Other Adult in Household

Date

Marquette Housing Commission - Annual Recertification Packet

Annual Income/ Asset/ Expense Checklist

Please check the box next to the income source(s) applicable to your entire household (current and anticipated in the 12-months following your recertification date), *then complete each field in that section* (enter "N/A" if is not applicable). **If an item does not apply, do not check the box and do not complete that section.**

Income from Employment: Job #1
Name of person employed _____
Employer Name _____ Employer Address _____
Human Resources/Payroll telephone # _____ Payroll Fax # _____
Supervisor Name _____ Supervisor phone # _____
Wage per hour \$ _____ Avg. hours worked per week _____ **OR** Monthly amount \$ _____
COMMENTS _____

Income from Employment: Job #2
Name of person employed _____
Employer Name _____ Employer Address _____
Human Resources/Payroll telephone # _____ Payroll Fax # _____
Supervisor Name _____ Supervisor phone # _____
Wage per hour \$ _____ Avg. hours worked per week _____ **OR** Monthly amount \$ _____
COMMENTS _____

Income from Employment: Job #3
Name of person employed _____
Employer Name _____ Employer Address _____
Human Resources/Payroll telephone # _____ Payroll Fax # _____
Supervisor Name _____ Supervisor phone # _____
Wage per hour \$ _____ Avg. hours worked per week _____ **OR** Monthly amount \$ _____
COMMENTS _____

Federal Social Security Income: Individual #1
Name of Person receiving benefit _____
Gross Monthly Benefit Amount \$ _____
Is this a Death Benefit award? ____ Yes ____ No
Are Medicare premiums deducted from this amount? ____ Yes ____ No Amount \$ _____
How long have you been receiving this exact amount? ____/____/____

Federal Social Security Income: Individual #2
Name of Person receiving benefit _____
Gross Monthly Benefit Amount \$ _____
Is this a Death Benefit award? ____ Yes ____ No
Are Medicare premiums deducted from this amount? ____ Yes ____ No Amount \$ _____
How long have you been receiving this exact amount? ____/____/____

Federal Social Security Disability Income (SSI or SSDI): Individual #1
Name of Person receiving benefit _____
Gross Monthly Benefit Amount \$ _____
Is this a Death Benefit award? ____ Yes ____ No (Continued...)

Are Medicaid premiums deducted from this amount? ____ Yes ____ No Amount \$ ____
How long have you been receiving this exact amount? ____/____/____

Federal Social Security Disability Income (SSI or SSDI): Individual #2

Name of Person receiving benefit _____
Gross Monthly Benefit Amount \$ _____
Is this a Death Benefit award? ____ Yes ____ No
Are Medicaid premiums deducted from this amount? ____ Yes ____ No Amount \$ ____
How long have you been receiving this exact amount? ____/____/____

State of Michigan Disability Income (Administered by the Dept. of Human Services)

Name of Person receiving benefit _____
Quarterly benefit amount \$ _____

Food Stamp Income

Name of Person receiving benefit _____
Monthly amount \$ _____ How long have you received this exact amount? ____/____/____
Name of DHS Case Manager _____

Financial Aid Income

To cover the costs of your higher education, do you currently or do you anticipate receiving in the next 12 months financial assistance in the form of a:

Grant
Amount \$ _____ When did/will you receive it? ____/____/____
Who received this money? _____
Source _____

Scholarship
Amount \$ _____ When did/will you receive it? ____/____/____
Who received this money? _____
Source _____

Loan
Amount \$ _____ When did/will you receive it? ____/____/____
Who received this money? _____
Source _____

Work-Study
Amount \$ _____ per _____ When did this take effect? ____/____/____
Place of Employment _____
Employer Phone _____ Fax _____
Supervisor Name _____ End date ____/____/____
COMMENTS _____

Income from Retirement or Veteran's Pension

Name of Beneficiary _____ Benefit amount \$ _____ per _____
Name of Source _____ Phone # _____
Address _____ Fax # _____

Income from Unemployment Benefits
Name of Beneficiary _____ Benefit amount \$ _____ per _____
Begin date ____/____/____ Anticipated end date ____/____/____
Comments _____
****You must provide your most recent benefit award statement at your recertification appointment**

Income from Worker's Compensation/ Disability Benefits/ Severance Pay
Name of Beneficiary _____ Benefit amount \$ _____ per _____
Name of Source _____ Phone # _____
Address _____ Fax # _____
Begin date ____/____/____ Anticipated end date ____/____/____
Comments _____

Child Support Income: Case #1
Amount \$ _____ per _____ Last payment made ____/____/____
Are there medical payments? Yes No Amount \$ _____ per _____
Name of child(ren) support is being paid on behalf of: _____
Is this Court-ordered? Yes No ***If Yes, you must bring the Judge's Order to your appt.**
Does Friend of the Court administer this? Yes No
Name of Payee _____ Name of Payer _____
Payer's phone # _____ Address _____
Comment _____

Child Support Income: Case #2
Amount \$ _____ per _____ Last payment made ____/____/____
Are there medical payments? Yes No Amount \$ _____ per _____
Name of child(ren) support is being paid on behalf of: _____
Is this Court-ordered? Yes No ***If Yes, you must bring the Judge's Order to your appt.**
Does Friend of the Court administer this? Yes No
Name of Payee _____ Name of Payer _____
Payer's phone # _____ Address _____
Comment _____

Income from Alimony/ Spousal Support
Name of Beneficiary _____ Amount \$ _____ per _____
Begin date ____/____/____ Anticipated end date ____/____/____
Payer Name _____ Phone # _____
Address _____
Is this Court-Ordered/Administered? Yes No ***If Yes, bring the Judge's Order to your appt.**
Comment _____

Income from Lottery Winnings
Name of Beneficiary _____ Amount \$ _____ per _____
Source _____

Income from Inheritance/ Death Benefits
Name of Beneficiary _____ Amount \$ _____ per _____
Last payment received ____/____/____ Source _____
Begin date ____/____/____ Anticipated end date ____/____/____
Attorney Name _____ Phone # _____ (Cont'd)...

Comment _____

TANF (Temporary Assistance for Needy Families)/FIP (Family Independence Program) Income

Name of Beneficiary _____ Amount \$ _____ per month
Date you begin receiving this amount ____/____/____ Case Manager Name _____

Income from Military Pay

Payee _____ Amount \$ _____ per _____
Source _____ Phone # _____
Address _____ Fax # _____
Comment _____

Income from Family, Friends, Non-Household Member(s) ****IMPORTANT: You MUST report ALL cash payments, recurring or otherwise, you receive from individuals/organizations AS WELL AS non-monetary contributions (payments or purchases) made on your behalf that you have been receiving or anticipate in the next 12-months (i.e. someone pays your insurance, phone bill, auto expenses, prescriptions, food, toiletries, clothing, rent, etc.) (Please use additional paper if you need more space to report such contributions).**

1. Person receiving assistance _____ Amount/value \$ _____ per _____
Source _____ Phone # _____
Address _____
Begin date ____/____/____ Anticipated end date ____/____/____
Comment _____

2. Person receiving assistance _____ Amount/value \$ _____ per _____
Source _____ Phone # _____
Address _____
Begin date ____/____/____ Anticipated end date ____/____/____
Comment _____

Lump Sum Payment (unemployment or welfare payments resulting from delays in processing)

Payee _____ Amount \$ _____
Receive Date ____/____/____ Source _____
Were attorney's fees involved? Yes No Amount \$ _____
Comment _____

OTHER INCOME NOT LISTED

Name of Beneficiary _____ Amount \$ _____ per _____
Source _____ Phone # _____
Address _____ Fax # _____
Comment _____

OTHER INCOME NOT LISTED

Name of Beneficiary _____ Amount \$ _____ per _____
Source _____ Phone # _____
Address _____ Fax # _____
Comment _____

Marquette Housing Commission - Annual Recertification Packet
Annual Income/ Asset/ Expense Checklist

Instructions: Please check the box next to the asset(s) applicable to your entire household (current and anticipated in the 12-month period following your recertification date), *then complete each field in that section* (enter "N/A" where something is not applicable). If the asset listed does not apply, do not check the box and do not complete that section. **You must disclose all disposed assets going back two years.**

IMPORTANT: If you are a WELLS FARGO account holder, you must bring your most recent bank statement(s) to your recertification appointment.

Checking Account: Account #1
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Checking Account: Account #2
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Savings Account: Account #1
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Savings Account: Account #2
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Certificate of Deposit (CD): #1
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Certificate of Deposit (CD): #2
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Money Market Fund: #1
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Money Market Fund: #2
Account holder Name(s) _____ Account # _____
Bank Name _____ Phone # _____
Address _____ Fax # _____
Is there a Rep. Payee or Co-Signatory? Yes No Name _____

Trust Fund
Beneficiary Name _____ Source _____
Comment _____

Investments/ Equity in Real Estate Property: #1
Owner/ Deed holder(s) _____
Financing Company/Bank Name _____ Phone # _____
Contact Person _____ Fax # _____
Property Address _____

Investments/ Equity in Real Estate Property: #2
Owner/ Deed holder(s) _____
Financing Company/Bank Name _____ Phone # _____
Contact Person _____ Fax # _____
Property Address _____

Stocks/ Bonds
Holder's Name _____
Financial Institution Name _____ Phone # _____
Address _____ Fax # _____

Stocks/ Bonds
Holder's Name _____
Financial Institution Name _____ Phone # _____
Address _____ Fax # _____

Treasury Bills/ Savings Bonds *Please bring copies of each to your recertification appointment.
Holder's Name _____ Amount \$ _____

Personal Property Held as an Investment: #1
Item(s) _____
Estimated Value \$ _____ Owner _____

Personal Property Held as an Investment: #2
Item(s) _____
Estimated Value \$ _____ Owner _____

WHOLE Life Insurance Policy: Policy #1
Policy Holder Name _____ Policy # _____
Provider/Company _____ Phone # _____
Fax # _____ Address _____

WHOLE Life Insurance Policy: Policy #2
Policy Holder Name _____ Policy # _____
Provider/Company _____ Agent Phone # _____
Fax # _____ Address _____

Retirement Account: #1
Policy Holder Name _____ Policy # _____
Provider Name _____ Agent Phone # _____
Fax # _____ Address _____
Type of Account _____

Retirement Account: #2
Policy Holder Name _____ Policy # _____
Provider Name _____ Agent Phone # _____
Fax # _____ Address _____
Type of Account _____

Capital Investment
Owner Name _____ Income/estimated value \$ _____
Type of property/investment _____
Comment _____

Lump Sum Payment (inheritances, insurance payments, capital gains, personal/property loss settlements, lottery winnings)
Beneficiary/Payee Name _____ Amount \$ _____
Receive Date ____/____/____ Source _____
Attorney's fees involved? YES NO Name/Phone _____
Comment _____

OTHER ASSET NOT LISTED
Owner Name _____ Estimated Value \$ _____
Type/Source _____
Contact Phone # _____ Contact Name _____
Address _____ Fax # _____
Comment _____

Marquette Housing Commission - Annual Recertification Packet

Annual Income/ Asset/ Expense Checklist

PLEASE BE ADVISED:

- Disability expenses are reasonable anticipated unreimbursed out-of-pocket expenses allowable when one or more family members is a person with a disability and if the expense enables a family member to work.
- Medical expenses are anticipated unreimbursed out-of-pocket expenses allowable when the Head-of-Household or Spouse is a person 62+ years of age, or if a family member is disabled.
- If the Head of Household or Spouse is elderly or disabled, each family member's medical expenses are allowable.

SECTION I: DISABILITY EXPENSES- Attendant Care (home nurses, aides, etc.) and Auxiliary Apparatuses (wheelchairs, vehicle/home adaptations, ramps, equipment for the blind, etc.)

1. In the 12-month period following your recertification date will any household member have unreimbursed out-of-pocket expenses for attendant care or auxiliary apparatuses? **YES** **NO**

If Yes, continue to Question 2. If No, skip to Section II, you do not qualify for disability expense deductions.

2. Is anyone in your household a person with a disability? **YES** **NO**

If Yes, continue to Question 3. If No, skip to Section II, you do not qualify for disability expense deductions.

3. Does the expense allow/qualify the disabled or another household member to work? **YES** **NO**

If Yes, your household qualifies for Disability Expense Allowances, please complete the checklist below. If No, skip to Section II, you do not qualify for disability expense allowances.

4. Is the Head of Household or Spouse a person with a disability? **YES** **NO**

If Yes, each family member's medical expenses are allowable.

Checklist Instructions: Please check the box next to the expense(s) applicable to your entire household (anticipated in the 12-month period following your recertification date), *then complete each field in that section.* Enter "N/A" where something is not applicable. If an expense listed does not apply, do not check the box and do not complete that section. Physician verification may be necessary before allowing the expense.

Disability Expense: Attendant Care#1 (bring documentation: contracts, receipts, etc. to your appointment)

Name of family member who receives/will receive the care _____

Caretaker Name/Agency or Company Name _____

Phone # _____ Address _____

How often care is given _____ hours per: Day Week Month (circle one)

Who is enabled to work as a result of this care? _____

COMMENTS _____

Disability Expense: Attendant Care#2 (bring documentation: service contracts, receipts, etc. to your appt.)

Name of family member who receives/will receive the care _____

Caretaker Name/Agency or Company Name _____

Phone # _____ Address _____

How often care is given _____ hours per: Day Week Month (circle one)

Who is enabled to work as a result of this care? _____

COMMENTS _____

Disability Expense: Auxiliary Apparatus Expense #1 (bring receipts, cost estimates, etc. to your appt.)
Name of family member who uses/will use the item _____
Item _____ Cost \$ _____
Date of Purchase _____ Place of Purchase _____
Phone # _____ Address _____
COMMENTS _____

Disability Expense: Auxiliary Apparatus Expense #2 (bring receipts, cost estimates, etc. to your appt.)
Name of family member who uses/will use the item _____
Item _____ Cost \$ _____
Date of Purchase _____ Place of Purchase _____
Phone # _____ Address _____
COMMENTS _____

Disability Expense: Auxiliary Apparatus Expense #3 (bring receipts, cost estimates, etc. to your appt.)
Name of family member who uses/will use the item _____
Item _____ Cost \$ _____
Date of Purchase _____ Place of Purchase _____
Phone # _____ Address _____
COMMENTS _____

SECTION II: MEDICAL EXPENSES- Insurance premiums, prescription/office visit co-pays, eyeglasses, hearing aid expenses, payments made toward a medical repayment plan, dental expenses, health care service expenses, etc.

1. Is the Head of Household or Spouse 62+ years old and/or Disabled? YES NO
If Yes, each household member's medical expenses are allowable, please complete the checklist below. If No, your household does not qualify for medical expense allowances/deductions- Skip to Section III.

Checklist Instructions: Please check the box next to the expense(s) applicable to your entire household (anticipated in the 12-month period following your recertification date), *then complete each field in that section.* Enter "N/A" where something is not applicable. If an expense listed does not apply, do not check the box and do not complete that section. Physician verification may be necessary before allowing the expense.

Medical Expense: Prescription Co-Pays, Pharmacy #1
Family Member Name _____ Pharmacy Name _____

Medical Expense: Prescription Co-Pays, Pharmacy #2
Family Member Name _____ Pharmacy Name _____

Medical Expense: Office Visit Co-Pays, #1 (please bring receipts from prior routine appointments)
Family Member Name _____ Physician Name _____
Physician Group/Practice Name _____
Patient Billing Dept. Phone # _____ Fax # _____
Address _____

Medical Expense: Office Visit Co-Pays, #2 (please bring receipts from prior routine appointments)
Family Member Name _____ Physician Name _____
Physician Group/Practice Name _____ (Cont'd)

Patient Billing Dept. Phone # _____ Fax # _____
Address _____

Medical Expense: Office Visit Co-Pays, #3 (please bring receipts from prior routine appointments)
Family Member Name _____ Physician Name _____
Physician Group/Practice Name _____
Patient Billing Dept. Phone # _____ Fax # _____
Address _____

Medical Expense: Office Visit Co-Pays, #4 (please bring receipts from prior routine appointments)
Family Member Name _____ Physician Name _____
Physician Group/Practice Name _____
Patient Billing Dept. Phone # _____ Fax # _____
Address _____

Medical Expense: Insurance Premium, Policy #1 (please bring your policy billing statement to your appt.)
Family Member Name _____
Insurance Provider/Company Name _____ Policy # _____
Insurance Phone # _____ Fax # _____

Medical Expense: Insurance Premium, Policy #2 (please bring your policy billing statement to your appt.)
Family Member Name _____
Insurance Provider/Company Name _____ Policy # _____
Insurance Phone # _____ Fax # _____

Medical Expense: Item #1 (please bring receipts, price estimates, etc. to your appt.)
Family Member Name _____ Cost \$ _____
Item _____ How often do you purchase these items? _____
Place of purchase _____

Medical Expense: Item #2 (please bring receipts, price estimates, etc. to your appt.)
Family Member Name _____ Cost \$ _____
Item _____ How often do you purchase these items? _____
Place of purchase _____

Medical Expense: Item #3 (please bring receipts, price estimates, etc. to your appt.)
Family Member Name _____ Cost \$ _____
Item _____ How often do you purchase these items? _____
Place of purchase _____

Medical Expense: Repayment Plan #1 (bring Repayment Agreement/Bill and payment receipts to your appt.)
Family Member Name _____ TOTAL repay amt. \$ _____
Service Provider Name _____ Phone # _____
Fax # _____ How often are payments made? _____
COMMENT _____

Medical Expense: Repayment Plan #2 (bring Repayment Agreement/Bill and payment receipts to your appt.)
Family Member Name _____ TOTAL repay amt. \$ _____
Service Provider Name _____ Phone # _____ (Cont'd)

Fax # _____ How often are payments made? _____
COMMENT _____

Medical Expense: OTHER NOT LISTED (please bring documentation to your appt.)
Family Member Name _____ Cost \$ _____
Item/Service _____ Contact _____
COMMENT _____

Medical Expense: OTHER NOT LISTED (please bring documentation to your appt.)
Family Member Name _____ Cost \$ _____
Item/Service _____ Contact _____
COMMENT _____

SECTION III: CHILD CARE EXPENSES- Reasonable, unreimbursed, out-of-pocket expenses anticipated by the family for the 12-month period following the recertification date. Family must provide written documentation that the childcare allows a family member to go to school, work, or seek employment, and child must be younger than 13.

1. Does anyone in your household pay for childcare expenses for a child under 13? YES NO
If Yes, continue to Question 2. If No, skip to the Tenant Certification below.

2. Does the childcare allow a family member to work, search for work, or attend school? YES NO
If yes, your childcare expenses are allowable up to the amount of income able to be earned by the childcare, therefore, please complete the checklist below. If No, skip to the Tenant Certification below.

Checklist Instructions: Please check the box next to the expense(s) applicable to your entire household (anticipated in the 12-month period following your recertification date), *then complete each field in that section.* Enter "N/A" where something is not applicable. If an expense listed does not apply, do not check the box and do not complete that section. Childcare verification will be necessary before allowing the expense.

Child Care Expense: Provider #1
Name(s) of Child(ren) receiving care _____
Provider Name _____ Phone # _____
Address _____ Fax # _____
Family Member enabled to work, search for work, or attend school: _____

Child Care Expense: Provider #2
Name(s) of Child(ren) receiving care _____
Provider Name _____ Phone # _____
Address _____ Fax # _____
Family Member enabled to work, search for work, or attend school: _____

Marquette Housing Commission - Annual Recertification Packet
Tenant Certification

Reporting Changes in Income or Household Composition

I understand my responsibility to report changes in my household's income within 10 days of the change using the "Tenant Report of Change" form. Further, I understand that the ONLY individuals who may reside in my subsidized unit are those who have been pre-screened and approved by the MHC. I understand the rules regarding guest/visitors and when I must report anyone who is temporarily staying with me.

No Duplicate Residence or Assistance

I certify that my unit being subsidized by the MHC is my principal residence and that I will not obtain duplicate federal housing assistance while I am a participant of the MHC's Section 8 Voucher or Public housing program. I will not live anywhere else without notifying the Housing Commission immediately in writing, nor will I sublease my assisted unit.

Cooperation

I understand the requirements to cooperate in supplying all information needed to determine my subsidy eligibility and to verify my true circumstances. Cooperation includes attending pre-scheduled meetings, completing and signing required forms as well as providing detailed contact information to verify my income, assets, medical expenses and true circumstances. I understand that per MHC Policy, failure or refusal to do so may result in delays in processing, a change from income-based calculation to a flat-rent assignment, termination of assistance, and/or eviction.

Criminal and Administrative Actions for False Information

I understand that knowingly supplying false, incomplete or inaccurate information is punishable under Federal or State criminal law and is grounds for termination of housing assistance or tenancy.

All household members age 18 and over must sign.

_____ Printed Name	_____ Signature	_____ Date
_____ Printed Name	_____ Signature	_____ Date
_____ Printed Name	_____ Signature	_____ Date
_____ Printed Name	_____ Signature	_____ Date

Marquette Housing Commission - Annual Recertification Packet
Personal Declaration

Please complete this form to verify your household composition. Begin with the Head of Household, and then list Co-Head/Spouse, then dependents.

FULL, LEGAL NAME	SEX	BIRTHDATE	SOCIAL SECURITY #	AGE
1. (Head of Household)				
2.				
3.				
4.				
5.				
6.				
7.				

TENANT CERTIFICATION

I, as Head of Household, certify that **ONLY** the individuals listed above live/will live in my subsidized unit. I am aware that no one else may live with me prior to MHC approval.

Signature _____

Date _____

Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD)
and the Housing Agency/Authority (HA)

U.S. Department of Housing
and Urban Development
Office of Public and Indian Housing

PHA requesting release of information: **(Cross out space if none)**
(Full address, name of contact person, and date)

IHA requesting release of information: **(Cross out space if none)**
(Full address, name of contact person, and date)

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(I)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

_____	_____		
Head of Household	Date		
_____		_____	_____
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
_____	_____	_____	_____
Spouse	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.