**Detroit CoC Rapid Re-Housing**

**Form #6- Household, Income, Asset, and Expense Declaration**

**Type:**  **New Admission**  **Annual Re-Examination**  **Interim Re-Examination**

**Next Annual Re-Examination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name & Mailing Address of Head of Household: | | Living address if different from Mailing: | | | | Return by: | | | | | |
|  | |  | | | | Sent: | | | | | |
| Email: | | Telephone: | | | | Cell Phone: | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Section A – Household Members/Family Composition** | | | | | | | | | | | |
| FAMILY COMPOSITION (List yourself and all other persons who will live in the unit, including Live-In Aide). Only those listed below are allowed to live in the subsidized unit. | | | | | | | | | | | |
| Name | Last four digits of social security number | | Relationship to  Head of Household | Birth Date | Age | |  |  |  |  |  |
| 1. |  | | Head of Household |  |  | |  |  |  |  |  |
| 2. |  | |  |  |  | |  |  |  |  |  |
| 3. |  | |  |  |  | |  |  |  |  |  |
| 4. |  | |  |  |  | |  |  |  |  |  |
| 5. |  | |  |  |  | |  |  |  |  |  |
| 6. |  | |  |  |  | |  |  |  |  |  |
| 7. |  | |  |  |  | |  |  |  |  |  |
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**RESPOND YES OR NO TO EACH QUESTION IN SECTIONS B, C, D AND E.**

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| **Section B – Income** | | | | | | | | |
| B1 | YES | NO | A member of the household is employed. List all jobs below and gross amount earned weekly  **(before deductions)**. | | | | | |
| **Household Member** | | | | **Employer** | **Employer’s Address, city, state, zip of source** | **Phone** | **Fax** | **Amount** |
| 1. | | | |  |  |  |  | $ |
| 2. | | | |  |  |  |  | $ |
| 3. | | | |  |  |  |  | $ |
| 4. | | | |  |  |  |  | $ |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| B2 | | | YES | | | | | | | NO | | | | A member of the household is self-employed.  If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per week? $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| B3 | | | YES | | | | | | | NO | | | | A member of the household receives tips. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | If yes, who: | | | | | | | | | | | | |  | | | | | | | | | | | | | How much per week? | | | | | | | | $ | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| B4 | | | YES | | | | | | | NO | | | | A member of the household receives unemployment benefits.  If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per week? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| B5 | | | YES | | | | | | NO | | | | | A member of the household receives monthly Social Security, Supplemental Security Income (SSI) or State Disability. List state and federal separately. If the payment is reduced to pay for Medicare put **“x”** in Medicare column. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | | | | | | Type SS, SSI, SDA | | | Medicare | Amount | | | Household Member | | | | | | Type SS, SSI, SSD | | | Medicare | | | | | Amount | | | |
| 1. | | | | | | | | | | | | | | | | | | |  | | |  |  | | | 3. | | | | | |  | | |  | | | | |  | | | |
| 2. | | | | | | | | | | | | | | | | | | |  | | |  |  | | | 4. | | | | | |  | | |  | | | | |  | | | |
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| B6 | | | YES | | | | | | NO | | | | | A member of the household receives military active duty allotments or Veterans Administration benefits. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | If yes, who: | | | | | | | | | | | | |  | | | | | | | | | Amount $ | | |  | | | | | | per | | | | |  | | |  | |
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| B7 | | YES | | | | | | NO | | | | | A member of the household receives workman’s compensation, disability or death benefits **other than Social Security**. If yes, monthly amount: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | | | | | | Source | | | Address, city, state, zip of source | | | | | | | Phone | | | Fax | | | | | | | | Amount | | | |
| 1. | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |  | | |  | | | | | | | |  | | | |
| 2. | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |  | | |  | | | | | | | |  | | | |
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| B8 | | YES | | | | | | NO | | | | | The family receives any type of public assistance from DHHS such as: TANF (cash assistance), food assistance, child day care or state SSI (usually $42 quarterly). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Program/Type of assistance | | | | | | | | | | | | | | | | | | | | | Amount | | | | | Program/Type of assistance | | | | | | | | | Amount | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | |  | | | | | 3. | | | | | | | | |  | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | |  | | | | | 4. | | | | | | | | |  | | | | | | | | |
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| B9 | | YES | | | | | | NO | | | | | A member of the household receives adoption assistance payments. If yes, list monthly amount: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | | | | | Source | | | | Address, city, state, zip of source | | | | | | | Phone | | Fax | | | | | | Amount | | | | | | |
| 1. | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | |  | |  | | | | | |  | | | | | | |
| 2. | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | |  | |  | | | | | |  | | | | | | |

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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B10 | | YES | | | | NO | | | | A member of the household receives child support and/or alimony. If yes, list monthly amount: | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | | | County | | | | | Child | Docket # | | | Court Award amount | | | Actual amount | | |
| 1. | | | | | | | | | | | | | | | |  | | | | |  |  | | |  | | |  | | |
| 2. | | | | | | | | | | | | | | | |  | | | | |  |  | | |  | | |  | | |
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| B11 | | YES | | | | NO | | | | A member of the household receives periodic payments from a trust, lottery, annuity, inheritance or insurance policies. If yes, list yearly amount: | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | Account Type | Bank/institution | | | | | Address, city, state, zip of source | | | | Phone | | | Fax | | | Amount | | | |
| 1. | | | | | | | | | | | | | |  |  | | | | |  | | | |  | | |  | | |  | | | |
| 2. | | | | | | | | | | | | | |  |  | | | | |  | | | |  | | |  | | |  | | | |
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| B12 | | | | YES | | | | | NO | | | | An adult member of the household is a student. If yes, complete: | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | School | | | | | | Address, city, state, zip of school | | | | Phone | | | Fax | | | Credit hrs | | | |
| 1. | | | | | | | | | | | | | |  | | | | | |  | | | |  | | |  | | |  | | | |
| 2. | | | | | | | | | | | | | |  | | | | | |  | | | |  | | |  | | |  | | | |
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| B13 | | | YES | | | | | NO | | | | Someone who does not live with me gives me or someone in my household cash or pays bills on my/their behalf. This includes payments that others make on your behalf for tuition, schooling, or other expenses (including monthly bills). If yes, list monthly amount: | | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | Name of person who provides assistance | | | | | Address, city, state, zip of source | | | | | Phone | | | Fax | | | Amount | | | |
| 1. | | | | | | | | | | | | | |  | | | | |  | | | | |  | | |  | | |  | | | |
| 2. | | | | | | | | | | | | | |  | | | | |  | | | | |  | | |  | | |  | | | |
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| B14 | | | YES | | | | | NO | | | | A member of the household has income earned or unearned not previously listed. If yes, list monthly amount: | | | | | | | | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | | | | | | Describe | | | | Address, city, state, zip of source | | | | | | Phone | | | Fax | | | Amount | | | |
| 1. | | | | | | | | | | | | | |  | | | |  | | | | | |  | | |  | | |  | | | |
| 2. | | | | | | | | | | | | | |  | | | |  | | | | | |  | | |  | | |  | | | |

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| Section C – Assets | | | | | | | | | |
| C1 | YES | | NO | A member of the household has assets such as, savings, checking, stocks, bonds, IRA’s etc. If yes, list account and current balance: | | | | | |
| Household Member | | | | Account Type | Bank/Institution | Address, city, state, zip of source | Phone | Fax | Balance |
| 1. | | | |  |  |  |  |  |  |
| 2. | | | |  |  |  |  |  |  |
| 3. | | | |  |  |  |  |  |  |
|  |  |  | |  | | | | | |

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| **Section D – Expenses** | | | | | | | | | | | | | | | | |
|  | |  |  | | | | |  | | | | | | | | |
| D1 | | YES | | | NO | | | A member of the household who is **elderly (age 62 or older) or disabled** pays medical insurance premiums, **other than** Medicare. If yes, complete: | | | | | | | | |
| Household Member | | | | | | | | | Insurance Company | Address, city, state, zip of source | Phone | | Fax | | Amount | |
| 1. | | | | | | | | |  |  |  | |  | |  | |
|  | |  |  | | | | |  | | | | | | | | |
| D2 | | YES | | | NO | | | A member of the household who is **elderly (age 62 or older) or disabled** and pays **Part D (drug) insurance premium** expense. If yes, complete: | | | | | | | | |
| Household Member | | | | | | | | | Insurance Company | Address, city, state, zip of source | Phone | Fax | | Amount | | |
| 1. | | | | | | | | |  |  |  |  | |  | | |
| 2. | | | | | | | | |  |  |  |  | |  | | |
|  | |  |  | | |  | | | | | | | | | | |
| D3 | YES | | | NO | | | A member of the household who is **elderly (age 62 or older) or disabled** pays for medical expenses or services, or handicap equipment that are not reimbursed by insurance or DHHS/other Agency | | | | | | | | |
| Household Member | | | | | | | | | Provider | Address, city, state, zip of source | Phone | Fax | | Amount | |
| 1. | | | | | | | | |  |  |  |  | |  | |
| 2. | | | | | | | | |  |  |  |  | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D4 | YES | NO | I pay childcare or handicap care expenses for a member of the household in order to be gainfully employed or to further my education. **NOTE:** Expense is not deductible if provider is a member of the household. If yes, list monthly amount: | | | | | |
| Household Member | | | | Provider | Address, city, state, zip of source | Phone | Fax | Amount |
| 1. | | | |  |  |  |  |  |
| 2. | | | |  |  |  |  |  |

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| **Section E – Other** | | | | | | | | | | | | | | | | | | | | |
| E1 | | YES | | NO | | If a member in the family is disabled, under the age of 62, and **does not** receive SSI, list the licensed health care provider who will verify the disability: | | | | | | | | | | | | | | |
| Household Member | | | | | | | | | Care Provider | | | Address, city, state, zip of source | | | | Phone | | | Fax | |
| 1. | | | | | | | | |  | | |  | | | |  | | |  | |
| 2. | | | | | | | | |  | | |  | | | |  | | |  | |
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| E2 | | YES | | NO | | I have a member of the household(s) age 5 or under who has an *identified* Environmental Intervention Blood Lead Level (EIBLL). | | | | | | | | | | | | | | |
|  | | List their names: | | | | | |  | | | | | | | | | | | |  |
| If yes, attach documentation indicating EIBLL. | | | | | | | | | | | | | | | | | | | | |
|  | |  | |  | | |  | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | | | |  |
| E3 | | Use this space to provide any additional general information or to complete questions above. To complete questions indicate the Question number and the information that was requested. | | | | | | | | | | | | | | | | | |  |
| Question # | | | | |  | | | | | | | | | | | | | | |  |
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|  | | | | |  | | | | | | | | | | | | | | |
| **Certification:**  .I certify that only the people listed in Section A, on page one of this form, will occupy the unit. I hereby attest that I have reviewed this entire form and that all of my family information, income, assets and expenses have been accurately reported. I understand that providing false information will result in denial or termination of benefits. I understand that I must report any change in income, expenses, household composition or assets within 14 calendar days of the change. | | | | | | | | | | | | | | **Certification:**  I certify that only the people listed in Section A, on page one of this form, will occupy the unit. I hereby attest that I have reviewed this entire form and that all of my family information, income, assets and expenses have been accurately reported. I understand that providing false information will result in denial or termination of benefits. I understand that I must report any change in income, expenses, household composition or assets within 14 calendar days of the change. | | | | | | |
|  | Signature Head of Household | | | | | | | | |  | Date | |  |  | Signature Spouse, Co-Head of Household or Other Adult | |  | Date | |  |
|  | Print Name: | | | | | | | | |  |  | |  |  | Print Name: | |  |  | |  |