**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. |  |  |  |  | $ |

|  |  |  |  |
| --- | --- | --- | --- |
| B2 | YES[ ]  | NO[ ]  | A member of the household is self-employed.If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per week? $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| B3 | YES[ ]  | NO[ ]  | A member of the household receives tips. |
|  | If yes, who:  |  | How much per week? | $ |  |
|  |
|  |  |  |  |
| B4 | YES[ ]  | NO[ ]  | A member of the household receives unemployment benefits. If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per week? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 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. |  |  |  |
|  |  |  |  |
| B6 | YES[ ]  | NO[ ]  | A member of the household receives military active duty allotments or Veterans Administration benefits.  |
|  | If yes, who:  |  | Amount $ |  | per |  |  |
|  |
|  |  |  |  |
| 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. |  |  |  |  |  |
|  |
|  |  |  |  |
| 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. |  |
|  |  |  |  |
| 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. |  |  |  |  |  |
|  |  |  |  |
|  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. |  |  |  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 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. |  |  |  |  |  |
|  |
|  |  |  |  |
| 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. |  |  |  |  |  |
|  |
|  |  |  |  |
| 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. |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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. |
|  |  |  |  |  |
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| 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 # |  |  |
|  |  |
|  |  |
| **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: |  |  |  |