Delano
MINNESOTA

Delano Economic Development Authority
"Serving Delano's Housing Needs"

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Delano, MN 55328

Application for Housing Assistance
And
Recertification of Eligibility

You are requesting a housing assistance payment through the Rental Assistance Program. Complete this form so that a decision can be made regarding your eligibility for a housing assistance payment.

Please complete each question of the form and sign the form on the back page.

I. APPLICANT

NAME_____

ADDRESS_____
Street, Box No. City County State Zip

TELEPHONE_____ _____
Home Work

If no telephone: How can we reach you:_____

II. HOUSEHOLD COMPOSITION: List each family member who will live in your household Including yourself. Clearly identify full- and part-time students over 18 years of age under relationship. (see bottom of page)

Name	Relationship to Household Head*	Sex (M or F)	Date of Birth (MM DD YYYY)	Soc. Sec. No.	Disability (Y/N)	Soc. Sec. or VA Claim No. **
1	Head					
2						
3						
4						
5						

NOTE: A full-time student who lives out of town, but returns home for at least three consecutive months per year, is allowed bedroom assignment. A part-time student living away from home is not allowed bedroom assignment.

Are you a Veteran? ____Yes ____No. Do you have a DD 214 Form ____Yes, ____ No

* S=Spouse, F=Foster Child, Y=Youth Under 18, E=Full Time Student, L=Live-in-Aide, A=other Adult
** See your Medicare and/or Medicaid Cards(s)

III. HEAD OF HOUSEHOLD CODE (Check one)

1. White _____
2. Black _____
3. Native American or Alaskan _____
4. Asian or Pacific Islander _____

Ethnicity (Check one)

1. Hispanic _____
2. Non-Hispanic _____

IV. OTHER CONTACT PERSON

If you need another person notified of changes in your rent, leases or other information please enter the information below:

Name_____
Address_____
City, State, Zip_____
Phone_____

If you are receiving Public Assistance, (AFDC, GENERAL ASSISTANCES, etc.) provide your case #, Supervisor, and their phone #.

Welfare #_____Supervisor_____Phone #_____

V. Assets. List assets for all household members. Each item must be checked "Yes" or No."

	Name and address of bank, credit union, or savings and Loan (Branch) which can verify this item.	Account No.
Checking Account: Yes_____No_____Amount $_____	_____ _____	_____ _____
Savings C.D.'s: Yes_____No_____Amount $_____	_____ _____	_____ _____
Bonds (any type): Yes_____No_____Amount $_____ (List Series, Face Amount, and month and year purchased on separate sheet).	_____ _____	_____ _____
Money Market Funds Yes_____No_____Amount $_____	_____ _____	_____ _____
Stocks: Yes_____No_____Amount $_____	_____ _____	_____ _____
Equity in Real Property Yes_____No_____Amount $_____ (Send county Treasurer's Tax statement. If you are making payments, please attach an amortization statement.)	_____ _____	_____ _____
Other: (Type)_____ Yes_____No_____Amount $_____	_____ _____	_____ _____

Have you disposed of any assets in the past two years?* Yes_____ No_____

If yes: what was disposed of?_____Value of Assets$_____

* If you have sold property Contract-for Deed, attach a copy of the contract and an amortization statement.

VI. INCOME

Declare the income for the head of the household, spouse and all household members age 18 and over who are currently receiving income or expect to receive income in the next 12 months. This includes family members who are temporarily absent, such as members serving in the Armed Forces, or members temporarily employed away from home. Benefits received on behalf of minors are also considered income.

EXAMPLES OF INCOME

YES	NO		
_____	_____	(U)	Unemployment or Workmen's Compensation/Severance Pay
_____	_____	(SS)	Social Security
_____	_____	(SI)	Supplemental Security Income
_____	_____	(PE)	Retirement of Pension Income (Annuities/Insurance Policies)
_____	_____	(D)	Public Assistance (AFDC)
_____	_____	(G)	General Assistance
_____	_____	(W)	Earned Income or Wages/Self Employment/Odd Jobs
_____	_____	(F)	Federal Wages
_____	_____	(N)	Contributions of Gifts
_____	_____	(B)	Net Income from a Business
_____	_____	(N)	Alimony
_____	_____	(CS)	Child Support/Child Support Pass Through
_____	_____	(M)	Military Pay (V.A. Benefits) Enter VA Claim Number#_____
_____	_____	(AI)	Income from Assets (Such as Savings, CD's Stocks, Etc.)
_____	_____	(N)	Lottery Winnings
_____	_____	(SI)	State Supplement for Supplemental Security Income
_____	_____	(I)	Leased Land Trust Income

Other (Please list any other income you or any members of your family receive.)

_____

_____

If you have checked yes to any of the above, please complete below:

Name of Family Member			
Name of Employer or Source of Income			
Address			
City, State, Zip			
Gross Income (Before Deductions)			
How Often Received M-Monthly B-Biweekly W-Weekly O-Other (explain)			

VII. FOR MEMBERS LISTED IN PART II AS DISABLED OR HANDICAPPED, THE EXTENT OF THE DISABILITY OR HANDICAP.

Name of Family Member	Type of Disability or Handicap
1.	
2.	

Do you have any unusual expenses related to employment, such as a care attendant or auxiliary apparatus for a handicapped or disabled family member? Yes_____ No_____

If Yes, Please explain_____

_____

* If you are a new applicant and the head of the household or the spouse is disabled or handicapped, your doctor will be contacted for proper verification.

Name of doctor	Address

Head of Household or spouse disabled? Yes_____ No_____
Head of Household or spouse 62 or older? Yes_____ No_____
If no to both of these, omit section VIII

VIII. MEDICAL EXPENSES (Medical expenses for elderly, disabled, or handicapped only.) Indicate on whose behalf medical expenses will be incurred for the next 12 months. Please attach a statement from the vendor (i.e. doctor, clinic, pharmacy, etc.) indicating the outstanding balance and the amount of monthly payment.

Name of Family Member	List name of doctor, hospital clinic, and/or drug store	Address	Medical Costs Montly	Medical Costs Annually
1.				
2.				
3.				
4.				

Name of Health Insurance Company_____

Premium $_____Mo._____Qtrly._____Annually_____

Please attach a statement from the company indicating the annual premium and the frequency of payment. Please attach receipts.

IX. CHILD CARE

Do you have child care costs related to working or going to school? Yes_____ No_____

Name of provider	Address	Phone #	Cost

X. FULL TIME STUDENT

Provide the following information for each household member show is 18 and a full time student. Attach additional sheets if necessary.

Name of Household Member	Name & Address of Education Institute
1.	
2.	

XI. LIVING ARRANGEMENT In what type of dwelling do you live? (Check one)

Rented home	_____	In home of relative	_____
Rented mobile home	_____	Rented apartment	_____
Own Home	_____	Public Housing	_____
Own mobile home	_____	Other Assisted living	_____
Lot Rent	_____	Other	_____

XII. PRIOR EVICTIONS

Have you or any member in your household been evicted from public assisted housing in the past 3 years? _____Yes _____ No

If yes, state reason and/or cause for eviction._____

_____

_____

If yes, name and address of property evicted from:_____

_____

_____

XIII. If you are divorced or legally separated and have not furnished us with documentation before, please attach Copies of divorce decree of legal separation agreement.

APPLICATION/TENANT CERTIFICATION

Applicant(s)/Tenant(s) Statement

I/We certify that the information given 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 of information are grounds for termination of housing assistance and termination of tenancy.

I hereby certify that I will report all changes of income, family composition, or assets within ten (10) days of the date of the change. My signature below constitutes my consent for the agency to obtain verifying information from any necessary source.

_____ _____

Signature or Mark of Head of Household | Signature or Mark of Spouse (living with you)

_____

DATE

Signature of Mark of all Household Members ages 18 or older.

_____

_____

Signature of Person, if any, who Helped you complete this form.

_____

_____

ADDRESS

_____

PHONE NUMBER

_____

RELATIONSHIP TO APPLICANT

If applicant signed with a mark "X", there must be two witnesses.

_____ _____ _____

Witness No 1 | Date | Witness No 2

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-free Hot Line at 800-424-8590.

* After certification by this Housing Agency, the information will be submitted to the Department of Housing and Urban Development on Form HUD-50058 (Family Report) or on magnetic media. See the Federal Privacy act Statement for more information about its use.