PLEASE LEAVE BLANK
OFFICE USE ONLY No.
RECEIVED:

ORD HOUSING AUTHORITY APPLICATION

Applicant Name: _____
Mailing Address: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____ Cell Phone: _____

Personal Declaration

This form must be completed in your own handwriting. You must use the correct legal name for each member of your household as it appears on the Social Security Card. All adult members of the household must sign below certifying the information pertaining to them. Please print.

Household Composition
List below all household members who will be living in the unit.

(Legal Name) First Name, Middle Initial, and Last Name	**Date of Birth**	**Relationship to Head of Household**	**Social Security Number**	**Place of Birth**
HEAD				

Please list any additional family members on the back of this application and check this box ☐

Do you anticipate a change in your family size in the next twelve months? Yes ___ No ___
If yes, explain changes below:

Are you separated? _____ Are you divorced? _____ If separated or divorced, fill in information of spouse/ex-spouse below, if known:

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Social Security #: _____ Social Security: _____

GENERAL INFORMATION

HUD requires that we obtain the following information for each family member. If a member is bi-racial, we ask that you indicate all races: Please use guide to the right and indicate which numbers apply.

	Race	Ethnicity
Head of Household	____	___
Spouse/Other Adult	____	___
Household Member	____	___
Household Member	____	____
Household Member	____	____
Household Member	____	____

Race
1 – White
2 – Black
3 – American Indian or Alaskan
4 – Asian
5 – Hawaiian/Pacific Islander
6 – Mixed: See above paragraph.

Ethnicity: Please mark A or B.
A – Hispanic
B – Non-Hispanic

Head of Household and/or Spouse: Please check one:
____ Non-Elderly ____ 62 Years or Older ____ Person with a Disability

1) Have you or any other adult members ever used any name(s) or Social Security number(s) other than the one you are currently using? Yes ___ No ___ If yes, explain below:
_____

2) Are you or any adult member of your family students? Yes ___ No ___ If yes, where do you attend school? _____

3) Have you or any member of your family lived in assisted housing? Yes ___ No ___ If yes, list where and when? _____

   Also, if yes, did you leave owing any monies for damages, past due rent or late charges in the assisted housing? Yes ___ No ___

4) Have you ever been requested to repay money knowingly misrepresenting information or committed any fraud in a Federally assisted housing program? Yes ___ No ___ If yes, explain : _____

5) Do you or any member of your household claim handicapped or disabled status for eligibility purposes? Yes ___ No ___ Do you draw SSI _____, VA Disability _____, SS Disability _____, Other _____ Explain: _____

6) Do you or any member of your household require a special needs dwelling unit? Yes ___ No ___ Explain: _____

7) How did you hear about our program? _____

8) Who is your caseworker at Social Services? _____
   Address_____

Have you or anyone listed on this application engaged in drug-related criminal activity or violent criminal activity, including criminal activity by any family member as defined below? Yes ___ No ___ If yes, please explain: _____

Crime by family members:

(a) **At any time, the HA may deny assistance to an applicant,** or terminate assistance to a participant family if any member of the family commits:
(1) Drug-related criminal activity; or
(2) Violent criminal activity

(b) **If the HA seeks to deny or terminate assistance** because of illegal use, or possession for personal use, of a controlled substance, such use or possession must have occurred within five years before the date that the HA provides notice to the family of the HA determination to deny or terminate assistance. The HA may not deny or terminate assistance for such use or possession by a family member, if the family member can demonstrate that he or she:
(1) Has an addiction to a controlled substance, has a record of such impairment, or is regarded as having such an impairment; and
(2) Is recovering, or has recovered from such an addiction and does not currently use or possess controlled substances. The HA may require a family member who has engaged in the illegal use of drugs to submit evidence of participation in, or successful completion of, a treatment program as a condition to being allowed to reside in the unit.

(c) **Evidence of criminal activity.** In determining whether to deny or terminate assistance based on drug-related criminal activity or violent criminal activity, the HA may deny or terminate assistance if the preponderance of evidence indicates that a family member has engaged in such activity, regardless of whether the family member has been arrested or convicted.

Taken from Housing and Urban Development (Code of Federal Regulations – CFR 24, CH. IZ 982.553 (4-1-97)

INCOME INFORMATION

List all money earned or received by everyone living in your household. This includes money from wages, self-employment, child support, contributions, Social Security(including Medicare), disability payments (SSI), Worker's Compensation, retirement benefits, AFDC, Veterans benefits, rental property income, stock dividends, income from bank accounts (including CD, savings, checking, and Money Market accounts), alimony, unemployment and all other sources.

	Head of Household	Spouse/Other Adult
Social Security/Medicare:	**$** _____	**$** _____
Gross Wages:	**$** _____	**$** _____
	Please indicate how often paid on gross wages.	
SSI:	**$** _____	**$** _____
Disability:	**$** _____	**$** _____
Pension/Retirement:	**$** _____	**$** _____
Rental Income:	**$** _____	**$** _____
Real Estate:	**$** _____	**$** _____

Child Support: $ _____ Payor _____ County _____ Case # _____

Names of Financial Institution(s) – Account Numbers
List: CD's, Checking, Savings, Money Market, Stocks, Bonds, IRA's, & %Of Interest

_____
_____
_____
_____
_____
_____
_____

1) Does anyone outside of your household pay for any of your bills or give you money?
   Yes ____ No ____ If yes, please explain: _____
   _____

2) Do you expect to receive any other income in the next twelve (12) months?
   Yes ___ No ___ If yes, from what source? _____

3) Employer Name: _____
   Employer Address: _____
   Date Employed: _____ Hours: _____ Wage: _____ HR/WK/MO

4) Employer Name:_____
   Employer Address: _____
   Date Employed: _____ Hours: _____ Wage: _____ HR/WK/MO

ASSET INFORMATION

1) Do you or any household member own or have any interest in any real estate, mobile home, or personal property held as an investment (such as gems, jewelry, coin collections, antique cars, boats, ect.)? Yes ___ No ___ If yes, please explain
   _____

2) Have you sold any real estate or disposed of any asset in the last two years?
   Yes ___ No ___ If yes, please explain _____
   _____

3) Do you own vehicle(s)? _____ Make/Model/Year _____

Make/Model/Year _____ License Plate #'s _____

MISCELLANEOUS INFORMATION

1) Do you or any member of your household claim handicapped or disabled status for eligibility purposes? Yes ___ No ___
2) Do you or any member of your household require a mobility free dwelling unit? Yes ___ No ___
3) Do you have Medicare? Yes ___ No ___ If yes, what is your Medicare number? _____
4) Do you receive medical assistance through the welfare department (Medicaid)? Yes ___ No ___
5) Do you have medical bills on which you are paying on a regular basis? Yes ___ No ___
6) Do you expect to have any medical expenses during the next twelve (12) months? Yes ___ No ___
7) In order to be employed, do you have daycare expense? Yes ___ No____
   If Yes Provider name and address_____

THE FOLLOWING SECTION NEEDS COMPLETED FOR ELDERLY, DISABLED, OR HANDICAPPED FAMILIES ONLY:

1) If you pay for a health insurance plan, please give us the amount you pay, whether it is monthly, quarterly, semi-annual, annual, your account and policy numbers, and what company you have the insurance with: _____
   _____
   _____
2) List below all Doctors/Hospitals and their addresses plus any other medical expenses you have paid in the last twelve months and **have not** been reimbursed by Medicare, Medicaid, or health insurance: _____
   _____
   _____
   _____
3) If you have prescriptions, please list below the name and address of the pharmacy you go to: _____
   _____
4) Did Medicare or your health insurance company pay for or reimburse you for any medical expenses in the past twelve months? Yes ___ No ___ If yes, you must enclose copies of the forms your received from the insurance agency or Medicare with this application form.

RENTAL HISTORY

Present landlord(s): Name: _____
Address: _____
Phone: _____

Your previous address: _____
Street Address City State Zip

_____
Move-In Date Move-Out Date Reason for Leaving

****

Previous landlord(s): Name: _____
Address: _____
Phone: _____

Your previous address: _____
Street Address City State Zip

_____
Move-In Date Move-Out Date Reason for Leaving

Person to call in case of emergencies:

Name: _____ Relation to you: _____

Address: _____ Phone Number: _____

All Applicants: Please read the following certification statement and sign where indicated. The Executive Director will assist you with any questions you may have.

Certified Statement: The information requested on this form is being collected in connection with regulations of the City of Ord Housing Authority, Ord, Nebraska authorized by the United States Department of Housing & Urban Development to determine an applicant's initial and continuing eligibility; unit size, and the amount of contribution by the tenant(s). It will be used to provide the basis for managing the program(s), for protecting the United States Government and the City of Ord Housing Authority's financial interest, and for verifying the accuracy of the information furnished. It may be released to appropriate Federal, State, and local agencies; when relevant, to civil, criminal, or regulatory investigators or prosecutors. Failure to provide any information may result in a delay, or rejection of eligibility approval, or subsequent determination that initially approved eligibility erroneous. General authorization to request this information is based on the Authority granted by the United States Housing Act of 1937, as amended, 42U.S.C., 1437 et seq., the Housing and Community Development Amendments of 1981, P.L. 97-35. 85 Statute, 348, 408.

WARNING: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.
****

Applicant(s)/Tenant(s) Statement:
I do hereby swear and attest that all of the information above about me is true and correct. All adults over the age of 18 must sign the application. I also understand that all changes in the income of any member of the household as well as any changes in the household members must be reported to the City of Ord Housing Authority in WRITING IMMEDIATELY.

_____ _____
Signature of Head of Household Date

_____ _____
Signature of Spouse or Other Adult Date

_____ _____
Signature of Other Adult Date

_____ _____
Signature of Other Adult Date

Equal Housing Opportunity