



PROGRAM UPDATE SHEET

Status: Applicant Tenant

Assistance Applied for (Check One): Public Housing Section 8

HASB USE ONLY: Date Received by HASB: _____ HASB Initials: _____

I. ADDRESS: (MUST COMPLETE THIS SECTION)

Is this an address change? YES NO

Name: _____
 (Last) (First) (Middle)

Address: _____
 (Street Number and Street Name) (Apt. Number)

 (City) (State) (Zip)

Phone: (_____) _____ **Social Security #:** _____

If there are no other changes besides an address change, please sign and date on the back of this form and return to the appropriate drop box.

II. HOUSEHOLD COMPOSITION: ADD DELETE

To request to add, you must provide a copy of a Birth Certificate, Social Security Card, and Picture ID (If person is over 18.)

<u>NAME</u>	<u>DISABLED</u> <u>Y/N</u>	<u>SEX</u> <u>M/F</u>	<u>RELATIONSHIP</u>	<u>BIRTH DATE</u>	<u>RACE</u>	<u>AGE</u>	<u>SOCIAL</u> <u>SECURITY#</u>

This agency is required to request disclosure of your Social Security Number pursuant to 24 C.F.R. Section 750, 10 and 118(a)(1), and to maintain information on race and gender pursuant to 24 C.F.R. 107.3(a).

III. EMPLOYMENT: Started Increase/Decrease (Please circle one) Stopped

Employer Name: _____

Address: _____

City, State, Zip: _____

No. of Hours per Week: _____ **Hourly Pay: \$** _____ **Effective Date:** _____

IV. OTHER INCOME SOURCES:

	Started:	Stopped:	Effective Date:	Monthly Payment:
	Please Check One:			
<input type="checkbox"/> TANF	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/> FOOD STAMPS	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/> SOCIAL SECURITY	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/> SSI	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/> CHILD SUPPORT	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/> OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____

Source: _____
 Address: _____
 City, State, Zip: _____

V. EXPENSES (Check One): STARTED STOPPED INCREASE/DECREASE MEDICAL
 CHILDCARE (IDWD PAY PORTION? Circle One Y / N)

Effective Date: _____

Source: _____

Address: _____

City, State, Zip: _____

VI. EDUCATION (Check One): STARTED STOPPED

School Name: _____

Address: _____

City, State, Zip: _____

No. of Credit Hours per Semester: _____

Effective Date: _____

CERTIFICATION STATEMENT: *I certify that all information provided in this update is true and correct and that falsification may constitute grounds for denial of assistance.*

 (Name)

 (Date)

 (Housing Representative)

OFFICE USE ONLY		
CHANGES	INPUT DATE	INITIAL
<input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> Household Composition		
<input type="checkbox"/> Employment		
<input type="checkbox"/> Other Income		
Source: _____		
<input type="checkbox"/> Education		