LUCAS METROPOLITAN
HOUSING AUTHORITY
211 S. BYRNE ROAD
TOLEDO, OH 43615

ANNUAL REEXAMINATION

FOR HOUSING CHOICE VOUCHER PROGRAM ASSISTANCE

Instructions

- ☑ **Fill out this packet completely. Do not leave any information blank. If the information does not apply to you, answer "NO", or write the word "NONE" or "N/A".**
- ☑ **Please print using blue or black ink; sign and date the bottom of each form.**

HOUSEHOLD/FAMILY INFORMATION

Household refers to all people who reside, with LMHA's permission, with you (including live-in aides, foster children and foster adults). Family refers to either a single person or a group of persons, whether related or not, residing together.

ADDRESS OF RESIDENCE: _____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

HOME PHONE: _____ **CELL PHONE**: _____

EMAIL: _____

List the correct legal name of all household members as it appears on their Social Security Card beginning with the head of household.

NAME OF HOUSEHOLD MEMBER	RELATION TO HEAD	Disabled? (Y/N)	AGE	DATE OF BIRTH	FULL-TIME STUDENT?* (Y/N)
	SELF				

For full-time students 18 years of age and older, attach current verification of student status.

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

List all persons who have moved out since your last annual recertification whose absence has not been previously reported *(death, marriage, moved to assisted living, etc.)*.

FULL NAME	RELATIONSHIP	DATE OF MOVE	REASON

Attach verification of the household member's new address such as a utility bill showing their name and new address.

LEAD POISONING SAFETY CHECK	YES	NO
1. Does anyone in the household under the age of six (6) have an Elevated Blood Level?	☐	☐
2. Has the minor been tested in the last year?	☐	☐

*If you answered **NO** to either or both questions, please skip to the next section.*

*If you answered **YES** to either or both questions, please continue with this form.*

Name of child: _____ Current lead level: _____

Date of last test:_____ *(please attach a copy of the test results)*

DRUG/CRIMINAL ACTIVITY	YES	NO
1. Have you or any household member ever been charged, arrested, or convicted for any drug-related or violent criminal activity? (excluding minor traffic offenses)	☐	☐
2. Have you or any household member ever been convicted of the manufacture or production of methamphetamine on the premises of assisted housing?	☐	☐
3. Are you or any household member subject to a lifetime sex offender registration requirement in any state?	☐	☐

*If you answered **NO** to all three questions, please skip to the next section.*

*If you answered **YES** to any of the questions continue with this form.*

Household member: _____Offense: _____

Date of offense: _____City, State: _____Name of courthouse: _____

Household member: _____Offense: _____

Date of offense: _____City, State: _____Name of courthouse: _____

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

INCOME/ASSETS

INCOME	YES	NO
1. Does any family member work full-time, part-time, or seasonally? Who? List employer: (attach last two pay stubs)	☐	☐
2. Has your employer changed since your last recertification? Previous employer: Current employer: Effective date: (attach separation letter)	☐	☐
3. Are any family members on a leave of absence from work due to layoff, medical leave, military leave, or maternity leave? Who? Type of leave: Expected date of return: (attach employer's statement to verify your dates of absence and payments received during this time)	☐	☐
4. Are any family members self-employed? Who? List business/profession or product/service: (attach last year's tax return, current year's business records, or your written statement of current earnings)	☐	☐
5. Does any family member receive money from rental property? Who? Amount: $ How often? (attach payment verification or your written statement of payments received)	☐	☐
6. Does any family member receive unemployment compensation? Who? (attach current payment printout)	☐	☐
7. Does any family member receive worker's compensation? Who? (attach current payment printout)	☐	☐
8. Does any family member receive Veteran's benefits? Who? (attach current payment printout)	☐	☐
9. Does any member of the family receive regular pay, special pay, or an allowance for a member of the Armed Forces? Who? Type: (attach current payment printout)	☐	☐
10. Does any family member receive retirement or pension income? Who? Type: Source: (attach current payment printout)	☐	☐
11. Does any family member receive benefits from the Social Security Administration? Who? Type: (attach current benefit letter)	☐	☐
12. Does any family member receive periodic or lump-sum payments from an insurance policy or an annuity? Who? (attach a current disbursement printout)	☐	☐
13. Does any family member receive cash assistance? Who? County: (attach current payment printout)	☐	☐
14. Has any family member stopped receiving cash assistance since your last recertification? Who? Why? (attach the decision letter)	☐	☐
15. Does any family member receive child support? Who? County: (attach "My Cases" page with 12-month printout of each open case)	☐	☐
16. Does any family member receive alimony? Who? County: (attach a 12-month printout)	☐	☐

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

INCOME	YES	NO
17. Has any family member stopped receiving child support or alimony since your last recertification? Who? Reason: *(*attach verification of last payment received)	☐	☐
18. Does anyone outside of your family pay for any of your bills? Amount: $ How often? Which bill(s)? (attach written statement from the person who can verify these payments)	☐	☐
19. Does anyone outside of your family give you cash for any reason other than paying your bills? Amount: $ How often? Reason: (attach written statement from the person who can verify these funds)	☐	☐
20. Does anyone outside of your family purchase or contribute any items for use in your home? Amount: $ How often? List items: (attach written statement from the person who can verify these items)	☐	☐
21. Does any family member receive student financial assistance that does not have their own parent residing with them in the household? ***(if yes, answer questions a <u>and</u> b; otherwise skip to question number 22)***	☐	☐

a. Is the person who receives student financial assistance age 18-23?

☐ YES ☐ NO *(circle one)*

b. Is the person who receives student financial assistance 24 years or older without their own dependent children in the household?

☐ YES ☐ NO *(circle one)*

ASSETS	YES	NO
22. Does any family member have a checking, savings, money market, CD, stocks, bonds or other investment accounts?	☐	☐

FAMILY MEMBER	*TYPE OF ACCOUNT*	*NAME OF BANK*	*CURRENT BALANCE*	*ANTICIPATED INTEREST IN NEXT 12 MONTHS*

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

ASSETS	YES	NO
23. Did any family member close a checking, savings, money market, CD, stocks, bonds or other investment accounts since last year's Annual Reexamination?	☐	☐

FAMILY MEMBER	*TYPE OF ACCOUNT*	*DATE CLOSED*

	YES	NO
24. Does any family member have cash on hand?	☐	☐

FAMILY MEMBER	*AMOUNT OF CASH ON HAND*

	YES	NO
25. Does any family member have a trust fund, irrevocable trust, IRA/Keogh, or retirement account?	☐	☐

FAMILY MEMBER	*TYPE OF ACCOUNT*	*FINANCIAL INSTITUTION*	*CURRENT BALANCE*

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

ASSETS	YES	NO
26. Does any family member have a life insurance policy? Who? Cash value: $ (attach current printout of policy)	☐	☐
27. Has any family member received a lump sum payment from an inheritance, lottery winning, insurance settlement or other claim? Who? Type: Amount: $ (attach payment verification)	☐	☐
28. Does any family member have their name on the title of any property, real estate or mobile home? Who? Address:	☐	☐
29. Has any family member sold or transferred property, real estate or mobile home? Who? Address: Sale/transfer date:	☐	☐
30. Does any family member have personal property held as an investment such as gems, jewelry, coin collections, stamps, sports memorabilia, sports trading cards (baseball/football/basketball cards), etc.? Who? Type: Estimated value: (attach recent appraisal form)	☐	☐
31. Does any family member earn or receive income that was not previously asked on this form? Who? Amount: How often? Source: (attach verification of this income)	☐	☐
32. Does any family member have any assets that were not previously asked on this form? Who? Type: Estimated value: (attach verification of the current value)	☐	☐

Head of Household _____ Date _____

EXPENSES

CHILDCARE EXPENSES

Child care expenses are reasonable anticipated unreimbursed expenses paid by the family for the care of household children 12 years of age and younger during the period for which annual income is computed, but only where the care is necessary to enable a family member to actively seek employment, to be gainfully employed or to further his/her education.

ELIGIBILITY QUESTION	YES	NO
1. Does any family member currently pay unreimbursed child care expenses for a child 12 years of age or younger?	☐	☐
2. Does the child care enable the family member to actively seek employment, to be gainfully employed or to further his/her education?	☐	☐

*If you answered **NO** to either question, you are not eligible for the child care expense. Please sign the bottom of this page and proceed to the next page.*

*If you answered **YES** to both questions, continue completing this page.*

1. Why is the childcare necessary? _____
2. Name of minor(s) receiving care: _____

   Full name of agency/private provider: _____

   Mailing address: _____

   City/State/Zip: _____

   Phone: _____ Fax: _____

To verify child care expenses, you will need to do the following:

- ☑ **Attach proof of why the childcare is necessary**
  - **Employment log of the family member actively seeking employment**
  - **Offer of employment letter or paystubs of the family member gainfully employed**
  - **School registration or class schedule of the family member furthering his/her education**
- ☑ **Attach proof of payments made to the childcare provider**
  - **Copies of your cancelled checks payable to the childcare provider**
  - **Printout of payments received or letter from the childcare provider**

☐ *I am aware that based on my household composition and my previous answers I may qualify for childcare expenses; however, I choose not to claim the expenses at this time. By checking this box and signing below I certify that I was given the option to have the expenses factored into the calculation of my household income.*

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

DISABILITY ASSISTANCE EXPENSES

Disability expenses are reasonable anticipated unreimbursed expenses to cover care attendants and auxiliary apparatus for any family member who is a person with disabilities, to the extent these expenses are necessary to enable a family member 18 years of age or older to work (including the family member who is a person with disabilities).

ELIGIBILITY QUESTION	YES	NO
1. Are you or any family member a person with a disability?	☐	☐
2. Do you or any family member currently pay unreimbursed expenses of care attendants or auxiliary apparatuses for any family member who is a person with disabilities in order to enable a family member 18 years of age or older to work?	☐	☐

*If you answered **NO** to either question, you are not eligible for the disability assistance expense. Please sign the bottom of this page and proceed to page number 10.*

*If you answered **YES** to both questions, continue completing this page.*

CARE ATTENDANT EXPENSE **(Costs for home medical care, nursing services, in-home or center-based care services, etc.)**	YES	NO
1. Does any family member currently pay unreimbursed care attendant expenses for any family member who is a person with disabilities in order to enable a family member 18 years of age or older to work?	☐	☐

*If you answered **YES** provide the following information:*

1. Describe service(s) provided: _____
2. Describe how the care attendant enables a family member to work: _____

   _____
3. Name of family member receiving attendant care: _____

   Full name of agency/private provider: _____

   Mailing address: _____

   City/State/Zip: _____

   Phone: _____ Fax: _____

To verify care attendant expenses, you will need to do the following:

- ☑ **Attach proof that the person with disabilities requires a care attendant**
  - **Written statement from knowledgeable medical professional**
- ☑ **Attach proof of employment**
  - **Offer of employment letter or paystubs of the family member gainfully employed**
- ☑ **Attach proof of payments made to the care attendant provider**
  - **Copies of your cancelled checks payable to the care attendant provider**
  - **Printout of payments received or letter from the care attendant provider**

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

AUXILIARY APPARATUS EXPENSE (items such as wheelchairs, ramps, adaptions to vehicles, etc.)	YES	NO
1. Does any family member currently pay unreimbursed auxiliary apparatus expenses for any family member who is a person with disabilities in order to enable a family member 18 years of age or older to work?	☐	☐

*If you answered **YES** provide the following information:*

1. List the auxiliary apparatus item(s):_____

   _____

2. Describe how each auxiliary apparatus item enables a family member to work: _____

   _____

3. Name of family member using the auxiliary apparatus item(s): _____

To verify auxiliary apparatus expenses, you will need to do the following:

- ☑ **Attach proof that the person with disabilities requires the auxiliary apparatus item(s)**
  - **Written statement from knowledgeable medical professional**
- ☑ **Attach proof of employment**
  - **Offer of employment letter or paystubs of the family member gainfully employed**
- ☑ **Attach proof of payments made for the auxiliary apparatus item(s)**
  - **Copies of invoice(s) and your cancelled check(s)**
  - **Paid receipt(s)**
  - **Billing statement(s) detailing total payments due for the upcoming 12 months**
    - **Must demonstrate evidence of payments being met**

☐ *I am aware that based on my household composition and my previous answers I may qualify for disability assistance expenses; however, I choose not to claim the expenses at this time. By checking this box and signing below I certify that I was given the option to have the expenses factored into the calculation of my household income.*

Head of Household _____ Date _____

THIS FORM MUST BE COMPLETED IN FULL

MEDICAL EXPENSES

Medical expenses are unreimbursed expenses anticipated to be incurred for any family member in the upcoming 12 months following your recertification date. The medical expense deduction is permitted only for households in which the head, spouse, or co-head is at least 62 years of age or disabled.

ELIGIBILITY QUESTION	YES	NO
1. Is the head of household, spouse or co-head age 62 or older?	☐	☐
2. Is the head of household, spouse or co-head disabled?	☐	☐

*If you answered **NO** to both questions, you are not eligible for medical expenses. Please sign the bottom of this page and return your completed Annual Reexamination paperwork to your Housing Specialist.*

*If you answered **YES** to either question, continue completing this page.*

MEDICAL EXPENSES	YES	NO
1. Does any family member pay for unreimbursed services of doctors or health care professionals?	☐	☐
2. Does any family member pay for unreimbursed services of heath care facilities?	☐	☐
3. Does any family member pay for unreimbursed medical insurance premiums?	☐	☐
4. Does any family member pay for unreimbursed prescription / non-prescription medicines prescribed by their physician?	☐	☐
5. Does any family member pay for unreimbursed transportation to treatment?	☐	☐
6. Does any family member pay for unreimbursed dental expenses, eyeglasses or hearing aids (including the hearing aid batteries)?	☐	☐
7. Does any family member pay for unreimbursed live-in or periodic medical assistance?	☐	☐
8. Does any family member pay unreimbursed monthly payments on accumulated medical bills?	☐	☐

To verify medical expenses, you will need to do the following:

- ☑ **Attach proof of payments made for the expenses you indicated *YES* to above**
  - **Copies of your cancelled checks**
  - **Printout from the medical provider of payments received**
  - **Statement of anticipated upcoming expenses from the medical provider**
  - **Transportation log that includes dates, name / addresses of facility and round trip mileage from your home**

☐ *I am aware that based on my household composition and my previous answers I may qualify for medical expenses; however, I choose not to claim the expenses at this time. By checking this box and signing below I certify that I was given the option to have the expenses factored into the calculation of my household income.*

Head of Household _____ Date _____

CERTIFICATION

1. I certify that my unit will be my **principal place of residency** and that I will not obtain duplicate federally assisted housing while I am a program participant; I will not **sublease** my unit; I will immediately give LMHA a copy of any owner eviction notice; I will not move out of my current unit before notifying LMHA and my landlord.

2. I understand that if I wish to **move** to another unit **with continued assistance** (either within LMHA's jurisdiction or outside LMHA's jurisdiction under portability) I must follow HUD regulations and LMHA's current policy before I will be allowed to move.

3. I understand that I am required to notify the Housing Authority in writing within 10 business days if any member of the family **moves out** of the unit.

4. I understand that I **cannot permit anyone to move into** my unit without prior approval of the Housing Authority and my landlord. Further, I must notify the Housing Authority in writing within 10 business days of any changes to the household due to birth, adoption, or court-awarded custody.

5. I understand that **any changes** in my household income must be reported to the Housing Authority in writing within 10 business days.

6. I understand that I **must supply** any information LMHA deems necessary in order to verify family composition, income or residency information.

7. I will **maintain all utilities** that I am responsible for under the lease agreement and I will not enter into side agreements/deals with the owner or owner's management agent.

8. Any **changes to the lease agreement and utilities** must be approved by LMHA before any changes are finalized with the owner.

9. I certify that my current unit **is not owned** by a parent, child, grandparent, grandchild, sister or brother of any member of the family; unless LMHA has approved my current tenancy due to a reasonable accommodation.

10. I understand that if my housing assistance from LMHA is terminated, the Housing Authority is required to report **outstanding money owed** them to the national HUD Debts Owed to PHAs database; LMHA may also engage in **collection activities** to obtain money owed and/or may refer my case to the office of Inspector General for Federal prosecution of program fraud.

Head of Household _____ Date _____

11. I acknowledge that LMHA reserves the right to **conduct criminal background checks,** including but not limited to sexual offenses, to determine my eligibility for admission to the Housing Choice Voucher Program and during periodic review(s) of my continued eligibility to participate in the Housing Choice Voucher Program.

12. I am aware that any person who attempts to obtain housing assistance or rent reduction by making **false statements,** by impersonation, by failure to disclose or intentionally concealing information, or any act of assistance to such attempt is a crime under Federal and State law.

13. All of the information I have provided on these re-examination forms is **true** and **complete**.

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES 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 AND SHELL BE FINED NOT MORE THAN $10,000 OR IMPRISONED FOR NOT MORE THAN FIVE YEARS OR BOTH.

_____ _____

Head of Household *Date*

_____ _____

Spouse/Co-Head or Household Member Over Age 18 *Date*

_____ _____

Household Member Over Age 18 *Date*

_____ _____

Household Member Over Age 18 *Date*

_____ _____

Household Member Over Age 18 *Date*

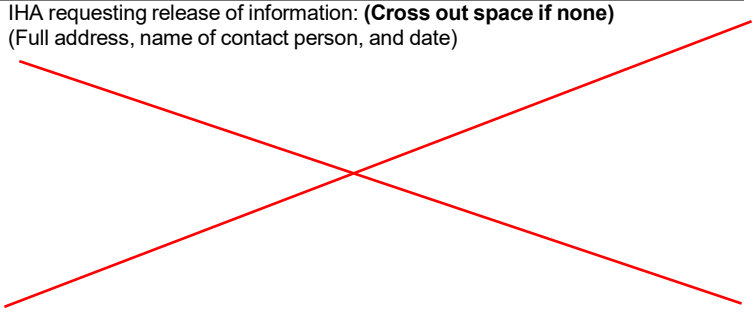
Head of Household _____ Date _____

Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

OMB CONTROL NUMBER: 2501-0014
exp. 07/31/2017

PHA requesting release of information; **(Cross out space if none)** (Full address, name of contact person, and date)	IHA requesting release of information: **(Cross out space if none)** (Full address, name of contact person, and date)
	

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termi- nation of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

Requesting Agency:
Lucas Metropolitan Housing Authority
Public Housing /Housing Choice Voucher Programs
211 S. Byrne Rd. Toledo, Ohio 43615

REQUEST FOR CRIMINAL HISTORY RECORD INFORMATION FOR NON-CRIMINAL JUSTICE PURPOSE

Authority: Title 24 Part 5 Section 903 of the Code of Federal Regulations authorizes any Public Housing Authority that administers the Housing Choice Voucher Program and/or a Public Housing programs to obtain criminal conviction records from a law enforcement agency, defined in Section 902.

Purpose: In signing this consent form, you allow the Lucas Metropolitan Housing (LMHA) to request and obtain criminal background/conviction records from law enforcement agencies via service provider.

Use of Information:

- Initial screening of Applicants and determination of continued eligibility for assistance under the Public Housing, Housing Choice Voucher (HCV) Program, Moderate Rehabilitation and Project-based Voucher Program.
- Initial screening of Applicants and determination of continued eligibility for assistance under the Project-Based Voucher Program, at the request of the Owner
- Enforcement of leases and eviction of residents by Public Housing and/or Section 8 Owner
- At re-examination, LMHA will conduct a criminal background check for each household member 18 years of age or older, including Live-In Aides.

Additional HCV Program Administrative Plan Requirements:

- Prior to granting approval to a family to port in or out of its jurisdiction, LMHA will conduct a criminal background check for each family member 18 years of age or older. If a criminal background check was conducted within the last 120 days by the jurisdiction from which the family is porting, LMHA will not conduct a criminal background check until re-examination.

****VAWA Protection:*** *Some types of criminal activity are also grounds for terminating a participant's assistance. If any member of the household (or guest, or any other person under the participant's control) engages in criminal activity directly related to domestic violence, dating violence, or stalking, and the participant or participant's immediate family member is a victim of this criminal activity, the PHA cannot terminate the victim's assistance because of this criminal activity.*

Consent: I consent to allow LMHA to request and obtain criminal background/conviction records from law enforcement agencies via service provider for the purpose of verifying my eligibility and/or continued assistance in the Housing Choice Voucher Program. This consent form expires 15 months from the signature date. Note that any information obtained pursuant to this consent may be utilized in accordance with 24 CFR 960.204 and 24 CFR 982.553, et seq.

(Turn page over)

***** THIS FORM MUST BE COMPLETED BY EACH ADULT 18 YEARS AND OLDER IN THE HOUSEHOLD*****

Name: (including Maiden Name, if applicable) _____
(First Name) (Middle Initial) (Last Name) (Maiden Name)

Address: _____ **Date of Birth:** _____
(Apt. #) (City, State, Zip Code) **(00/00/0000**) (Month/Day/Year)

☐ **Male** ☐ **Female** **Race:** _____ **Social Security Number:** _____

Signature: _____ **Date:** _____
(Head of Household**)**

Name: (including Maiden Name, if applicable) _____
(First Name) (Middle Initial) (Last Name) (Maiden Name)

Address: _____ **Date of Birth:** _____
(Apt. #) (City, State, Zip Code) **(00/00/0000**) (Month/Day/Year)

☐ **Male** ☐ **Female** **Race:** _____ **Social Security Number:** **XXX – XX -** _____

Signature: _____ **Date:** _____
(Other family member over age 18**)**

Name: (including Maiden Name, if applicable) _____
(First Name) (Middle Initial) (Last Name) (Maiden Name)

Address: _____ **Date of Birth:** _____
(Apt. #) (City, State, Zip Code) **(00/00/0000**) (Month/Day/Year)

☐ **Male** ☐ **Female** **Race:** _____ **Social Security Number:** **XXX – XX -** _____

Signature: _____ **Date:** _____
(Other family member over age 18**)**

Name: (including Maiden Name, if applicable) _____
(First Name) (Middle Initial) (Last Name) (Maiden Name)

Address: _____ **Date of Birth:** _____
(Apt. #) (City, State, Zip Code) **(00/00/0000**) (Month/Day/Year)

☐ **Male** ☐ **Female** **Race:** _____ **Social Security Number:** _____

Signature: _____ **Date:** _____
(Other family member over age 18**)**

The Lucas Metropolitan Housing Authority's

Family Self-Sufficiency Program: Transitioning to Financial Independence

The Family Self-Sufficiency Program (FSS) is a voluntary program based on a five-year contract and escrow account (for eligible participants) to financial self-sufficiency, but some participants complete the program in less time. FSS help eligible participants set attainable goals such as returning to school, additional job training, owning a home, and starting a small business!

Get Excited About Your Future! If you are interested, please fill out the form below.

PLEASE PRINT

Name: _____ **Address**: _____

City/State/Zip: _____

Telephone Number: _____ **Best Time to Contact**: _____

Email Address: _____

Areas of Interest: (Check All That Apply)

EDUCATION
- ☐ GED/High School Education
- ☐ Vocational/Technical College/College Education
- ☐ Other (please specify) _____

CAREER COUNSELING
- ☐ Interests Assessment
- ☐ Skills Assessment

JOB SEARCH
- ☐ Application Process
- ☐ Resume/CV Assistance
- ☐ Interview Techniques

FINANCIAL COACHING
- ☐ Budgeting
- ☐ Crediting Counseling
- ☐ Debt Consolidation

HEALTH CARE ISSUES
- ☐ Affordable health care
- ☐ Nutrition counseling
- ☐ Smoking cessation

FAMILY LIFE
- ☐ Volunteer work
- ☐ Parenting Counseling
- ☐ Problems with school

HOUSING
- ☐ Homeownership Program
- ☐ Energy assistance
- ☐ Rental assistance

OTHER
- ☐ Alcohol/Drug issues
- ☐ Food assistance
- ☐ Starting a business
- ☐ Life strategies
- ☐ Gambling addiction

EMOTIONAL HEALTH
- ☐ Depression
- ☐ Personal/family counseling
- ☐ Stress management
- ☐ Grief counseling

Office Use Only