



Portage Metropolitan Housing Authority

Section 8 Department

2832 State Route 59, Ravenna, Ohio 44266 | Telephone: (330) 297-1489 Fax: (330) 577-0000
 •Equal Housing Opportunity•

Personal Declaration

You must complete this form. You must use the correct legal name for each member of your household. **ALL** adult members of the household (18 years and older) must sign at the end of this form certifying the information pertaining to them is true and correct. **PLEASE PRINT. PARTIAL/INCOMPLETE FORMS WILL NOT BE ACCEPTED.**

Name/Head of Household _____ Telephone Number (____) _____

Unit Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

I. HOUSEHOLD COMPOSITION: List all persons who reside in or, for requests to add household members, will reside in your home, listing head of household first. **Do not list household members who are absent from the home.**

Family Member #	NAME <small>(as it appears on Social Security Card)</small>	Age	Date of Birth	Male or Female	Relationship to Head of Household	Student <small>(Yes or No)</small>	Social Security Number
1					SELF		
2							
3							
4							
5							
6							
7							
8							
9							
10							

Do you have custody of any/all minor children listed above? Yes or No (circle one). If no, please explain in the space that follows.

II. HOUSEHOLD INCOME: List all money earned or received by everyone living in your household. This includes, but is not limited to, money from employment (including tips, bonuses, commissions, etc.), self-employment, child support, alimony, ANY cash assistance, veteran's benefits, rental property income, interest income, contributions/money given to you on a routine basis, etc.

YOU MUST ANSWER EVERY QUESTION—COMPLETE ALL BOXES BELOW:
 Check Yes or No and enter the Family Member Number(s) that are beside each name as listed above

Type of Income	Yes	No	Family Member #	Monthly Amount
Employment				
Tips				
Bonuses				
Commissions				
Self-/Employment				
Social Security				
SSI				
Pension				
VA Pension				
Disability (other than SS/SSI)				
Unemployment Benefits				
Public Assistance (Cash Assistance)				
Public Assistance (Supplemental Nutrition Assistance Program fka "Food Stamps")				
Worker's Comp				
Alimony				

Type of Income	Yes	No	Family Member #	Monthly Amount
Child Support (Specify County: _____)				
Savings Account				
Checking Accounts				
CD's/Stocks/Bonds/etc				
IRA/Keogh Accts.				
Real Estate/Rental Income				
Investments or Trusts				
Lump Sum Receipts				
Grants				
Scholarships				
Stipends				
Disposed of Assets (last 2 years)				
Other (specify)				
Other (specify)				
Other (specify)				

ALL employment information for EACH family member must be listed below.

Family Member #	Employer's Name, Address & Telephone Number	Hourly Rate	Average Hours Worked (per week)

ALL asset information for EACH family member must be listed below. This includes assets that are non-interest bearing.

Family Member #	Bank's Name, Address & Telephone Number	Account #	Checking or Savings	Balance

III. ALLOWANCES/DEDUCTIONS

If all adult household members work (or go to school), do you pay for Child Care Expenses that are paid by you and not paid for or reimbursed by an outside agency or source? Yes _____ No _____ If yes, please list the Child Care Provider's **name, address and telephone number:** _____ . Amount paid \$ _____ per _____ week or _____ month

Is any adult in household attending College, Job Training or GED courses? _____ If so, where? _____ Completion date? _____ Does ADULT full-time student have a grade point average of 2.0 or higher? _____

If yes, which ADULT student(s)? _____ Does the student attend part-time or full-time? _____

Are you 62 or older? Yes _____ No _____ Are you handicapped? Yes _____ No _____ Are you disabled? Yes _____ No _____

Do you require special accommodations? Yes _____ No _____ If yes, please specify _____

If yes to either of the above, do you: 1) pay for your own medical insurance? Yes _____ No _____ 2) pay out-of-pocket medical expenses that are not paid for or reimbursed by your insurance or another source? Yes _____ No _____ If yes, list name & address of location of where expense is paid _____

IV. GENERAL INFORMATION

Does anyone outside of your household help with your household bills or living expenses? Yes _____ No _____

If yes, explain, _____

Have your public assistance benefits been reduced (sanctioned) due to failure of any member of the family to comply with work activity requirements? Yes _____ No _____

Have you or any member of your household ever used any name(s) or Social Security Number(s) other than the one you are currently using? Yes _____ No _____ If yes, explain _____

Have you or any member of your household ever lived in subsidized housing (housing in which your rent is based on your income)? Yes _____ No _____ If yes, list where and when _____

Have you ever committed fraud in or been evicted from any Federally assisted housing program or been requested to repay money for misrepresenting information for such housing programs? Yes _____ No _____ If yes, explain _____

Do you own property? Yes _____ No _____ If yes, please list address(es) _____

V. ALTERNATE/EMERGENCY CONTACTS

In an emergency or if you are unable to contact me, please contact the following individuals :

(1) Name _____	(2) Name _____
Address _____	Address _____
Phone # () _____	Phone # () _____
Relationship _____	Relationship _____

AFTER READING THE FOLLOWING STATEMENTS PLEASE SIGN AND DATE BELOW.

I/we certify that the information given to the Portage Metropolitan Housing Authority on household composition, income, net family assets, allowances and deductions is accurate and complete to the best of my/our knowledge and belief. I/we understand that false statements or information are punishable under Federal law. I/we also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy. As an applicant/participant of the Section 8 program, I understand that all CHANGES in my household's income and family composition must be reported, in writing, to PMHA within 5 business days of when the change occurs. Any information, document or signature needed to verify the change must be provided within 10 business days of the change.

_____ SIGNATURE OF HEAD OF HOUSEHOLD	_____ DATE	_____ SIGNATURE OF SPOUSE/CO-HEAD	_____ DATE
_____ SIGNATURE OF OTHER ADULT MEMBER	_____ DATE	_____ SIGNATURE OF OTHER ADULT MEMBER	_____ DATE
_____ SIGNATURE OF OTHER ADULT MEMBER	_____ DATE	_____ SIGNATURE OF OTHER ADULT MEMBER	_____ DATE

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.