

Scituate Housing Authority  
 Rockland Oaks  
 104 Rockland road  
 Scituate, RI 02857



## Application For Public Housing

- A. 1. Name \_\_\_\_\_ Tel. No. \_\_\_\_\_
2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. How long have you lived at your present address? \_\_\_\_\_
4. List your former address \_\_\_\_\_
5. Marital Status: Single  Married
6. If Divorced or Separated: Name of Former Spouse \_\_\_\_\_
7. Maiden Name (if different from above) \_\_\_\_\_
- B. 1. Are you a veteran? YES  NO  Induction Date \_\_\_\_\_ Discharge Date \_\_\_\_\_
2. Are you receiving veteran's benefits as the family of a serviceman? YES  NO
3. Are you a disabled veteran? YES  NO  Service Serial No. \_\_\_\_\_
- C. List the names and phone numbers of two friends or relatives that we can contact if we are unable to reach you.
- Name \_\_\_\_\_ Tel. No. \_\_\_\_\_
- Name \_\_\_\_\_ Tel. No. \_\_\_\_\_
- D. Have you been convicted of a felony within the last five years? YES  NO  if so, when and state the conviction: \_\_\_\_\_
- E. List all persons including yourself, who will live in this rental unit while you are on this program, list head of the household first as Number one (1) and then each family member. Use your proper Family Member Number (No.) in the following sections.

Family Member No.	Full Name	Place of Birth	Relationship to Family Head	Sex	Date of Birth	Social Security No.	Occupation
1			HEAD				
2							
3							
4							
5							
6							
7							
8							
9							
10							

**F. EMPLOYMENT**

List all full and/or part-time employment anticipated within the next 12 months for all Household members (other than minor, dependent- children under the age of 18)

• If self employed use net income from business. (Depreciation of property is allowed, and should be based on the straight line method used for tax purposes.)

Family Member No./Name	Name & Address of Employer	Gross Earnings	Wk./Mo./Yr.
1. _____	_____	\$ _____	per _____
2. _____	_____	\$ _____	per _____
3. _____	_____	\$ _____	per _____
4. _____	_____	\$ _____	per _____
5. _____	_____	\$ _____	per _____

**G. OTHER SOURCES OF INCOME**

List ALL income anticipated within the next 12 months by each family member.

Family Member No.	1.	2.	3.	4.	5.
	\$	\$	\$	\$	\$
1. Welfare					
2. Social Security					
3. SSI					
4. Pension					
5. VA Benefits					
6. Unemployment					
7. Alimony					
8. Child Support					
9. Excess Tax Credit					
10. Other					

**H. ASSET INFORMATION**

Name of Bank	Amount	Account No.
Checking: _____	_____	_____
Savings: _____	_____	_____
Savings Certificates: _____	Annual Interest Received: _____	Value: _____
Stocks and Bonds: _____	Annual Dividend Received: _____	Value: _____
Property Owned, Address: _____	_____	Value: _____
Other, Explain: _____	Income Rec'd Monthly: _____	Value: _____

Assets disposed of within the last 2 years for less than Market Value, please explain:

\_\_\_\_\_

\_\_\_\_\_

**I. MEDICAL EXPENSES**

**Elderly families only (Age 62 handicapped or disabled)**

Do you pay any portion of the cost of Medical/Insurance/Hospitalization Coverage (i.e. Blue Cross, Medicare, Etc.)

YES  NO  if yes, how much? \$ \_\_\_\_\_

List separately all medical expenses and amounts that are not covered by Medical Insurance (i.e. prescriptions, Non-prescription drugs, etc.)

\_\_\_\_\_

\_\_\_\_\_

**J. HANDICAPPED ASSISTANCE EXPENSES**

List handicapped assistance expenses that are anticipated during the next 12 months. Include attendant care and auxiliary apparatus for Handicapped or Disabled Family members that are necessary to enable a Family member (including the Handicapped or Disabled member) to be employed, provided that the expenses are not reimbursed by an outside source.

Family Member No.	Person/Agency	Address	Description	Cost Weekly

If any special apparatus is needed for handicapped/disabled family members to work, or necessary to enable another family member to work, list items here. Description: \_\_\_\_\_ Cost: \_\_\_\_\_

Does any member of your household use a wheelchair? YES  NO

Does any member require special housing facilities? YES  NO

Explain: \_\_\_\_\_

\_\_\_\_\_

**K. CHILD CARE EXPENSES**

Fill in the amounts you anticipate to pay in the next 12 months for children under the age of 13\*. Complete this section only if: The purpose of the child care is to allow a family member to be gainfully employed or further his/her education.

Do you pay for child cares? YES  NO  if yes, list Child Care provider. Cost per week \$ \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

**L. PROGRAM INFORMATION**

1. Have you been displaced by a fire, a natural disaster or public action? YES  NO   
if yes, explain \_\_\_\_\_
2. Is your present housing condemned? YES  NO
3. Is your present housing substandard? YES  NO   
Present monthly rent \$ \_\_\_\_\_ No. of Bedrooms \_\_\_\_\_  
Does the rent and utilities represent more than 50% of your monthly income? YES  NO   
Utilities: please list all utilities paid by you  
a. Heat \$ \_\_\_\_\_ per month  
b. Electric \$ \_\_\_\_\_ per month  
c. Other \$ \_\_\_\_\_ per month
4. Have you ever applied for Public Housing or participated in a Rental Assistance Program? YES  NO   
if yes, where and explain \_\_\_\_\_
5. Are you living in or have you ever lived in Public Housing? YES  NO   
if yes, where \_\_\_\_\_
6. Do you owe any back rent to the Johnston Housing Authority or to any former or current landlord? YES  NO   
if yes, explain \_\_\_\_\_
7. Have you ever been evicted or violated your lease while participating in a Public Housing Program? YES  NO
8. What is the name, address and telephone number of your current landlord?  
\_\_\_\_\_
9. What is the name, address and telephone number of your former landlord?  
\_\_\_\_\_

Please feel free to use additional paper if necessary when answering any of the above questions.

**M. RACIAL DATA:**

The following information is required for statistical purposes so the department of HUD may determine the degree to which its programs are utilized by minority families.

- WHITE  BLACK  AMERICAN INDIAN or ALASKAN NATIVE  ASIAN or PACIFIC ISLANDER   
HISPANIC  NON-HISPANIC

**WARNING: false statements or information on this application are grounds to terminate your application for housing assistance, and are punishable under Federal and State Law.**

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important: If you move, you are required to notify the Authority in writing or you cannot be considered for assistance.**

## Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

**SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING**

This form is to be provided to each applicant for federally assisted housing

**Instructions: Optional Contact Person or Organization:** You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. You may update, remove, or change the information you provide on this form at any time. You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	Cell Phone No:
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	Cell Phone No:
E-Mail Address (if applicable):	
Relationship to Applicant:	
Reason for Contact: (Check all that apply)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Assist with Recertification Process
<input type="checkbox"/> Unable to contact you	<input type="checkbox"/> Change in lease terms
<input type="checkbox"/> Termination of rental assistance	<input type="checkbox"/> Change in house rules
<input type="checkbox"/> Eviction from unit	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Late payment of rent	
Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.	
Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.	

Check this box if you choose not to provide the contact information.

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Signature of Applicant

Date

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. HUD meets statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550 authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actors.

Form HUD-92005 (05-09)