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Southeast Kansas Community Action Program, Inc.

Recipient of the "Award for Excellence" in Community Action

CHANGE OF STATUS
PERSONAL DECLARATION FORM

NAME: ______________________ **DATE:** ____________________

PHONE: ☐HOME____________________ ☐WORK ____________________
☐CELL____________________ ☐MESSAGE ____________________

CHANGES BEING MADE: (1) ☐ADDRESS (2) ☐HOUSEHOLD MEMBERS
(3) ☐INCOME (4) ☐NO CHANGES TO REPORT

1) CHANGE OF ADDRESS TO: ________________________________
DATE NEW ADDRESS IS EFFECTIVE:________________________________

2) CHANGE OF HOUSEHOLD MEMBERS
LIST ALL PERSONS LIVING IN YOUR HOME NOW:

a.	b.
c.	d.
e.	f.
g.	h.

List only those persons below who you are ADDING TO OR REMOVING FROM your home.

RACE: B = Black, W = White, A = Asian, AI =American Indian, H = Hawaiian or Pacific Islander, M = Mixed

ETHNICITY: H = Hispanic, N = Non-Hispanic

I AM ADDING: ☐ I AM REMOVING: ☐ FULL NAME	*Spouse *Son *Daughter *Other Adult *Live-In Aide	AGE	BIRTH DATE	SEX	SOCIAL SECURITY NUMBER	RACE Circle All That Apply	ETHNIC Circle One
						B W A AI H M	H N
						B W A AI H M	H N
						B W A AI H M	H N
						B W A AI H M	H N

3) CHANGE IN INCOME:

EXPLAIN:____
____
____
____

Question	YES	NO
Do you have custody of minor children who live with you?	☐YES	☐NO
If NOT: Are you working with an agency to obtain custody?	☐YES	☐NO
Do you have a Reintegration Plan?	☐ YES	☐ NO
Do you wish to declare you or your spouse disabled or handicapped?	☐YES	☐NO
If you have been assisted in other federal subsidized housing, do you owe them money? WHERE:	☐YES	☐NO
STUDENT STATUS:		
Are you or a member of your household a college student?	☐YES	☐NO

Are you or any members of your household subject to registration to meet the requirement by a State Sex Offender Registration Program?

☐Yes ☐No Identify who: ____

Have you or any member of your household ever been convicted of production or manufacture of meth? ☐YES ☐NO Identify who: ________________________________

Have you or any member of your household been evicted from assisted housing due to drug related or criminal activity in the past (3) years? ☐YES ☐NO
Identify who: ____

Have you or any member of your family been convicted or arrested for drug related or criminal activity in the past five (5) years? ☐Yes ☐No Identify who: ____________________
YEAR: ____________Identify Charge: ____

NAME ANY STATE YOU AND/OR ANY FAMILY MEMBER HAVE RESIDED:

____

APPLICANT/TENANT CERTIFICATION STATEMENT:

I/We certify that the information* given to the SEK-CAP, Inc. Housing 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 and State law. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

____ ____________________________

Signature / Head of Household **Date:**

____ ____________________________

Signature of Spouse or other Adult member **Date:**

If you believe you have been discriminated against you may call the Fair Housing An Equal Opportunity National Toll free Hot Line at 800-424-8590.

***After verification by this Housing Agency the information will be submitted to the Department of Housing and Urban Development on Form HUD-50058 (Tenant Data Summary) a computer generated facsimile of the form or on magnetic tape. See the federal Privacy Act Statement for more information about its use.**

NOTE: *"Warning: Section 1001 of Title 18 of the United States Code makes it a criminal offense to make a willfully false statement or misrepresentation to a Department or Agency of the United States as to any matter within its jurisdiction."*
WARNING: ANY PART OF THIS APPLICATION FOUND TO BE ERRONEOUS DUE TO FALSE STATEMENTS OR MISREPRESENTATIONS WILL RESULT IN THE PHA PLACING YOUR APPLICATION INACTIVE IMMEDIATELY.

INCOME AND/OR BENEFIT SOURCES

YOU MUST REPORT INCOME RECEIVED BY ANY HOUSEHOLD MEMBER.

Check all that apply	Household Member	Income/Benefit Amount & Frequency	Source of Income/Benefit
☐ No Household Income			
☐ DCF CASH ASSISTANCE			
☐ DCF FOOD ASSISTANCE			
☐ General Assistance			
☐ Child Support or Alimony			
KPC PIN #: ____________________			
☐ Social Security			
☐ SSI			
☐ Wages from Employment			
☐ Unemployment Benefits			
☐ Worker's Compensation			
☐ Child Care Business			
☐ Net Income from a Business			
☐ Odd Jobs			
☐ Pension or Trust Funds			
☐ Military Pay/VA Benefits			
☐ Student Financial Aid			
☐ Regular Contribution or Gifts (Money given to you by someone)			
☐ Other, Explain:			
ASSETS	**Household Member**	**Value of Asset**	**Source of Asset**
☐ Savings Acct./Checking Acct.			
☐ CD's, stocks, bonds, etc.			
☐ Rental Property			
☐ Real Estate			
Sold: Value:			

SIGNATURE OF ADULT REPRESENTATIVE DATE

EXPENSES/DEDUCTIONS

Child care deduction:

☐ I pay out of pocket child care expenses for a child under 13; AND I am
☐ employed, or ☐ going to school, or ☐ seeking employment

Name of Child:	Expense Amount:	Expense Paid To:

Elderly/Disabled household deductions:

☐ Head of Household/Spouse/Co-Head is 62 or older
☐ Head of Household/Spouse/Co-Head is disabled/handicapped

Medical Expense deductions:

☐ Head of Household/Spouse/Co-Head is disabled/handicapped
☐ Household member(s) have medical expenses that are:
- regular, on-going for the next 12 months
- unreimbursed (not covered by an outside source)

If you checked this box, you may report medical expenses for ALL household members to qualify for a deduction:

Household Member:	Expense Amount:	Expense Paid To:

Disability Assistance Expense Deduction:

☐ A household member with a disability requires attendant care of auxiliary apparatus AND there are out of pocket expenses associated with this.

Household Member:	Expense Amount:	Expense Paid To:

Earned Income Disallowance (EID):

☐ A household member is disabled and experienced an increase in income.

No Expenses or Deductions:

☐ The deductions and expenses described are NOT APPLICABLE to my household.

SIGNATURE OF ADULT REPRESENTATIVE DATE

Authorization for Release of Confidential Information

I/WE ____

authorize the release of any/all information as requested for the purpose of determining eligibility for assistance. I further authorize SEK-CAP to release any of my case information internally, or to other agencies and vendors necessary to reach a determination on my request for assistance.

This authorization for release of information is valid until it is revoked in writing.

______________________________	_________________	________________
Head of Household Signature	SSN	Date

______________________________	_________________	________________
Co-Head/Other Adult Signature	SSN	Date

______________________________	_________________	________________
Other Adult Signature	SSN	Date