SEK-CAP
Southeast Kansas Community Action Program, Inc.

401 N. Sinnet
P.O. Box 128
Girard, KS 66743

P. 620-724-8204
F. 620-724-8741
www.sek-cap.com

Compassion in Action!

Tenant Based Rental Assistance (TBRA) Homeless Assistance Program Waiting List Opens December 11th, 2023

If you require assistance completing your application, need this application packet mailed to you, or have any questions please contact us using any of the methods listed below.

1. Apply for the TBRA waiting list at https://sekcap.housingmanager.com/. Waiting list applications must be completed online or you can call our office to complete a telephone assisted application.

2. Complete the enclosed TBRA Application Packet and submit required documents along with the application packet. All questions must be answered. Incomplete paperwork will delay the processing of your application.

3. Contact the nearest Agency Partner listed on the attached sheet to complete an **ASSESSMENT** and obtain a **HOMELESS CERTIFICATION** to determine your level of need for services. TBRA applicants will be prioritized for services based on level of need.

4. **Please make sure we have a reliable mailing address, phone number, and email address.** If we are unable to contact you, we will remove you from the waitlist, so let us know immediately if your contact information changes.

5. Paperwork can be hand-delivered, mailed, faxed, or emailed:

   SEK-CAP Housing
   401 N. Sinnet/PO Box 128
   Girard, KS 66743

   Fax: (620)724-8741

   Email: housinginfo@sek-cap.com

   If you need assistance completing the required paperwork, or need assistance with the homeless certification and assessment, please contact:
   Jacob Hughes – 620-238-0380
   Assistance with Assessment – https://www.kshomeless.com/help-request-form.html

TBRA Income Limits

Effective 05/15/2023

	Most Counties*	Linn County
1 PERSON HOUSEHOLD-----	$27,000	$35,900
2 PERSON HOUSEHOLD-----	$30,850	$41,000
3 PERSON HOUSEHOLD-----	$34,700	$46,150
4 PERSON HOUSEHOLD-----	$38,550	$51,250
5 PERSON HOUSEHOLD-----	$41,650	$55,350
6 PERSON HOUSEHOLD-----	$44,750	$59,450
7 PERSON HOUSEHOLD-----	$47,850	$63,550
8 PERSON HOUSEHOLD-----	$50,900	$67,650

***Most Counties Includes Allen, Bourbon, Chautauqua, Cherokee, Crawford, Elk, Labette, Montgomery, Neosho, Woodson, and Wilson Counties.**

Housing Services
401 N. Sinnet / P.O. Box 128
Phone: (620)724-8204
Fax: (620)724-8741
Email: housinginfo@sek-cap.com

TBRA Application Packet – Required Documentation Checklist

PLEASE USE BLACK OR BLUE INK ONLY (NO LIGHT COLORS)!
PLEASE FULLY COMPLETE ALL INCLUDED FORMS!

Verification of eligibility is required for participation in the Tenant Based Rental Assistance (TBRA) program. Submit program forms and required applicable documentation noted below by mail/fax/email to SEK-CAP by the deadline date. Incomplete forms will be returned for your completion and will delay processing your application.

IDENTIFICATION REQUIRED:

- ☐ Copy of Photo ID for all adult household members
- ☐ Copy of Social Security Cards for ALL household members
- ☐ Copy of Birth Certificates for all household members under 18

INCOME INFORMATION REQUIRED: (If applicable to your family)

- ☐ Food assistance benefit letter
- ☐ Cash assistance benefit letter
- ☐ Unemployment award letter – https://www.dol.ks.gov/unemployment
- ☐ Current SS or SSI award letter – https://www.ssa.gov/myaccount/ or **call 1-800-772-1213**
  Provide asset verification for how you receive SS or SSI (bank statement, copy of card with all but last four digits of the card number blacked out & ATM balance inquiry, copy of most recent check).
- ☐ Child Support – Copy of child support court order (divorce decree) & KPC PIN # **(Call 1-877-572-5722).**
- ☐ Alimony – Copy of court order.
- ☐ Students – Financial Aid award letter, proof of enrolment, and proof of tuition and book expenses.
- ☐ Pension or retirement award letter.
- ☐ Employment – Last 3 months paystubs (must be consecutive) or employer printout.
- ☐ Regular contributions from family member or friend – Provide letter from family member or friend stating how much they provide and how often. (Must be signed, dated, and have their contact information).

DEDUCTIONS: (If applicable to your family)

- ☐ **Elderly/Disabled Family Deduction** – If head of household, spouse, co-head, or sole member is at least 62 years old OR a person with disabilities, the family may be eligible for deductions:
  Provide receipts or proof of payment for unreimbursed, out of pocket medical expense for ALL family members.
  Provide proof of disability status, if applicable. (i.e., letter from medical professional stating you are disabled).
- ☐ **Disability Assistance Expense Deduction** – If ANY member of your household is disabled, you may qualify for a Disability Assistance Expense:
  Provide proof of payment for any expense related to the disability, which enable a household member to work.
- ☐ **Child Care Deduction** – If you pay out of pocket child care expenses for a child under the age of 13, you may be eligible for a childcare expense deduction:
  Provide proof of payment for these expenses.

HOMELESS CERTIFICATION & CES ASSESSMENT (REQUIRED!!!)

☐ **Homeless Certification** – Completed by an Agency Partner (list provided)

☐ **Coordinated Entry System Assessment (CES)** – Completed by an Agency Partner (list provided)
Assist with Assessment – https://www.kshomeless.com/help-request-form.html

OTHER REQUIRED INFORMATION: (If applicable to your family)

☐ **Assets** – Provide verification of assets (checking/savings accounts, CDs, etc.).

☐ **Reintegration Plan** – For each child you do not currently have custody of but will once appropriate housing is obtained. Please complete all paperwork and provide all required documentation for the child(ren).

☐ **Drug-related or other criminal activity** – If any adult member of the household has a felony conviction in the last three (3) years, please provide a 3rd party letter from the parole or probation officer stating that there have been no convictions, drug related activity, or other criminal activity in the preceding 6 months.
If there is no parole or probation officer, this would need to come from a social service agency, employment supervisor, or landlord.

FULLY COMPLETE ALL INCLUDED FORMS

☐ **Application Update Packet**
Page 1 – Complete every line and answer all questions.
Page 2 – Complete every line, answer all questions, sign and date.
Page 3 – Check each box that applies and complete information, sign and date.
Page 4 – If any Expense/Deduction applies complete information, if they do not apply mark box on bottom of page, sign and date.

☐ **Basic Intake Form**
Fully complete every line, sign and date at the bottom of page.

☐ **HUD 92006 (Optional Contact Form)**
Complete first three lines with Head of Households information.
If wanting an additional contact, enter information for Additional Contact Person or Organization.
If not wanting additional contact, please mark the box at the bottom of the page.
Head of household signs and dates at bottom of the page.

☐ **Citizenship Form(s) - Complete for every person in the household**
Adults – Mark appropriate box, print their name, sign their name, and date.
Children – Mark appropriate box, print their name, signature of adult, and date.

☐ **Authorization for Release of Confidential Information – 3 Pages**
SEK-CAP Authorization Page – Fill out completely
Lead Safe Housing Authorization Page – Fill out completely
Coordinated Entry Authorization Page – Fill out completely

☐ **Student Status Affidavit**
Each adult member must fully complete.
Print name and date at the top, answer the question under this.
If **NO**, skip the questions – If **YES**, answer questions 1-10
Sign and date at the bottom.

☐ **Zero/Little Income Questionnaire**
Each adult member must fully complete this form.
Mark every box either YES or NO and answer all questions below.
Sign and date at the bottom.

☐ **Custody/Child Support & Alimony Affidavit – IF APPLICABLE**
Complete one form for **EACH** absent parent.
Fully complete all questions and provide documentation outlining custody and child support.

TBRA Partner Agencies

CES Assessment - All Counties

Kansas Statewide Homeless Coalition

https://www.kshomeless.com/help-request-form.html

Allen County

Agency	Phone Number	Homeless Certification	CES Assessment	Referral Type
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	X	Domestic Violence Victims Only
Humanity House	620-380-6664	X		All Welcome
Thrive Allen County	620-365-8128	X		All Welcome
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Bourbon County

Agency	Phone Number	Homeless Certification	CES Assessment	Referral Type
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
SEK Mental Health Center	620-223-5030	X		All Welcome
TFI Family Services	620-371-8724	X		Clients Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Chautauqua County

Agency	Phone Number	Homeless Certification	CES Assessment	Referral Type
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Cherokee County

Agency	Phone Number	Homeless Certification	CES Assessment	Referral Type
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Crawford County

Agency	Phone Number	Homeless Certification	CES Assessment	Referral Type
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
Crawford County Mental Health	620-231-5130	X	X	All Welcome
Family Response Advocate	620-687-5668	X		Clients Only
Wesley House	620-232-3760	X	X	All Welcome
City of Pittsburg	620-232-1210	X	X	All Welcome Inside Pittsburg
Salvation Army	620.231.0415	X		All Welcome
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Elk County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Labette County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
Emergency Assistance Center	620-421-0700			Call Ahead, Assist with Paperwork
CHC of SEK (Parsons)	620-717-4450	X		Clients Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Linn County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
SEK Mental Health Center	913-352-8214	X		All Welcome
TFI Family Services	620-371-8724	X		Clients Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Montgomery County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
CHC of SEK (Coffeyville)	620-251-4300	X		Clients Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Neosho County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	X	Domestic Violence Victims Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Wilson County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	X	Domestic Violence Victims Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

Woodson County				
Agency	**Phone Number**	**Homeless Certification**	**CES Assessment**	**Referral Type**
Catholic Charities	620-235-0633	X	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	X	Domestic Violence Victims Only
SEK-CAP, Inc.	620-238-0380	X	X	All Welcome

SEK-CAP TBRA Program Homeless Certification

Name of Applicant: _____ Referral Agency: _____

This is to certify that the above named individual or household is currently homeless based on the check mark and signature indicating their current living situation. In signing this form, the agency and applicant are certifying that, to the best of their knowledge, the information provided is true. This form must be completed by a participating agency, designated by SEK-CAP. **Select the living situation that currently applies to the applicant by placing an 'X' in the box:**

Category 1

☐ Has a primary nighttime residence that is a public or private place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

☐ Living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations.

☐ Exiting an institution where (s)he has resided for 90 days or less AND who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2

☐ Will imminently lose their primary nighttime residence, provided that the following circumstances are true:

a) Residence will be lost within 14 days of the date of application for homeless assistance;
b) No subsequent residence has been identified; AND
c) The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Category 3

☐ Unaccompanied youth under 25 years of age (must be 18 or older), or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

a) Are defined as homeless under the other listed federal statutes;
b) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
c) Have experienced persistent instability as measured by two moves or more during the preceding 60 days; AND
d) Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Category 4

☐ Any individual or family who:

a) Is fleeing, or is attempting to flee, domestic violence;
b) Has no other residence; AND
c) Lacks the resources or support networks to obtain other permanent housing

Authorized Referral Agency Representative (Printed Name, Signature, & Date)

Applicant (Printed Name, Signature & Date)

SEK-CAP

HOUSING ASSISTANCE
APPLICATION UPDATE

NOTE: IF YOU NEED SPECIAL ACCOMODATIONS TO COMPLETE THIS APPLICATION, PLEASE NOTIFY A REPRESENTATIVE AT THIS TIME.

Date:_____ Time:_____

Name (Head of Household):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Mailing Address Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

PHONE: ☐**HOME**_____ ☐**WORK** _____
☐**CELL**_____ ☐**MESSAGE** _____

EMAIL: _____

List all persons below (including yourself) who will reside in the rental unit.

Full Name	**Self Spouse Son Daughter Other Adult**	**Age**	**Birth Date**	**Sex**	**Social Security #**	**B = Black W = White A = Asian AI = American Indian H = Hawaiian or Pacific Islander M = Mixed** **Circle all that apply** **Race**	**H= Hispanic N = Non Hispanic** **Circle One** **Ethnic**
						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**
						B W A AI H M	**H N**
						B W A AI H M	**H N**
						B W A AI H M	**H N**

Do you have custody of minor children living 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

CERTIFICATION

Name every state you and members of your household have resided:

_____

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:_____ YEAR:_____

Have you or any member of your family been convicted or arrested for drug related or criminal activity in the past three (3) years? ☐Yes ☐No Identify who: _____
YEAR: _____Identify Charge: _____

PARTICIPANT/APPLICANT STATEMENT:

I/We certify that the information* given to SEK-CAP, Inc. on household composition, criminal history, 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 denial or 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 any 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			
☐ Wages from Employment			
☐ 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

SEK-CAP, Inc. Housing – Basic Intake Form(BIF)

Date: _____ /_____ /_____ **Email:** _____

Applicant/HoH Name: _____ **Date of Birth:** _____ / _____ / _____ **Gender:** M / F **Disabled?** Yes / No
(First, MI, Last)

Heath Insurance? Yes / No ***Race:** _____ ***Ethnicity:** _____ ***Education Level Completed:** _____ ***Military Status:** _____

# of Persons in Household: _____ ***Family Type:** _____ ***Housing Type:** _____ **Phone Number:** _____

Household Member Information – Other than Applicant/HoH

Relation to Applicant	Full Name (First, MI, Last)	DOB	Gender	Disabled (Y/N/U)	Health Insurance (Y/N/U)	*Race	*Ethnicity	*Education Level Completed	*Military Status

States in which adult household members have lived:

Relation to Applicant	*Ethnicity	*Race	* Housing Type	* Family Type	*Education Level	*Military Status
S = Sibling	H = Hispanic	A = American Ind./Alaska Nat.	O = Own	S = Single Parent Female	0 = 0-8	R = Reserves
P = Parent	NH = Non-Hispanic	AA = Asian	R = Rent	SS = Single Parent Male	9 = 9-12 (not-grad)	A = Active
C = Child		B = Black/African American	H = Homeless	TT = 2 Parent Household	H = High School Grad (GED)	U = Unknown
SP = Spouse or Partner		H = Hawaiian/Pacific Islander	O = Other	SSS = Single Person	12+ = 12 Plus some Post-Secondary	N = None
GP = Grandparent		W = White	U = Unknown	T = 2 Adults/No Children	2-4 = 2-4 Yr. College Grad	
G = Grandchild		O = Other		M = Multigenerational House	U = Unknown	
F = Foster		M = Multi-race		O = Other		
GG = Guardian		For Multi-race please indicate:		U = Unknown		
O = Other		(i.e. BW, AH, AAO, etc.)				

I have provided this information voluntarily and understand that it will be used: 1) to aid in determining eligibility for SEK-CAP, Inc. programs; 2) to report non-identifiable demographic information required by funders; and 3) to comply with central data system reporting. It may be made known to other persons in pursuit of these ends. It will be kept confidential pursuant to the Privacy Act of 1874, As Amended, subject to the limits set out above. I certify that the information provided here and on other SEK-Cap, Inc. application documents is correct and complete and understand that any false statements could result in the denial of services.

Applicant/HoH Signature: _____ Date:_____

OMB Control # 2502-0581
Exp. (02/28/2019)

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)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

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.

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. It supports 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 actions.

TBRA / HOUSING CHOICE VOUCHER PROGRAM
DECLARATION OF CITIZENSHIP STATUS

Notice to applicants and tenants: To be eligible to receive the housing assistance sought, each applicant for, or recipient of, housing assistance must be lawfully within the U.S. Please read the Declaration statement carefully and sign.

☐ .....* **CITIZEN** - A citizen of the United States.

☐ .....* **NATIONAL** - A person who owes permanent allegiance to the United States, for example, because of birth in a United States territory or possession. (Other documentation required)

☐ .....* **NONCITIZEN** - A person who is neither a citizen nor a national of the United States. (Other documentation required)

☐ .....* **NONCITIZEN STUDENT -** A person who has a residence in a foreign country and has no intention of abandoning, is a bonafide student qualified to pursue a full course of study and is admitted to the U.S. temporarily and solely for purposes of pursuing such course of study at a recognized place of study and specifically designated and approved by the AG. (Ineligible for assistance/use prorated calculation for families which include citizens or eligible immigrants)

UNDER PENALTY OF PERJURY, I certify the information noted above is accurate and up-to-date, AND I AM LAWFULLY WITHIN THE UNITED STATES and can provide appropriate documentation as required. I certify the signature below is that of an approved family representative.

_____

PRINT NAME OF HOUSEHOLD MEMBER

_____ _____

SIGNATURE OF PERSON DECLARING OR FAMILY REPRESENTATIVE SIGNATURE
(If person declaring is child under age 17.)

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

SEK-CAP
Southeast Kansas Community Action Program, Inc.

401 N. Sinnet
P.O. Box 128
Girard, KS 66743

P. 620-724-8204
F. 620-724-8741
www.sek-cap.com

Compassion in Action!

Authorization for Release of Confidential Information
Lead Safe Housing

In accordance with the Department of Housing and Urban Development's Lead Safe Housing Rule found in 24 CFR § 35.1225, Southeast Kansas Community Action Program (SEK-CAP) is required to determine and report whether children less than 6 years of age with elevated blood lead levels are residing in SEK-CAP assisted rental units.

As the parent and/or guardian, I consent to personal health information in the form or names and addresses of children less than 6 years of age with an elevated blood lead level living the identified tenant-based unit receiving rental assistance being shared between the Kansas Department of Health and Environment and SEK-CAP for purposes of complying with 24 CFR § 35.1225.

By signing this authorization, you are giving permission for the Kansas Department of Health and Environment to release and receive relevant health information for any child less than 6 years of age with an elevated blood lead level living in the identified SEK-CAP assisted rental unit.

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

_____	_____	_____
Head of Household – Signature	Printed Name	Date
_____	_____	_____
Other Adult – Signature	Printed Name	Date

Southeast Kansas Coordinated Entry
Authorization of Disclosure of Confidential Information

I, _____, date of birth: (DD/MM/YYYY) _____, last four of SSN: XXX-XX-_____, authorize the following agencies to disclose information to each other in order to coordinate services that will help me to obtain and maintain safe and affordable housing:

- Southeast Kansas Community Action Program (SEK-CAP) - All Programs
- Catholic Charities of Southeast Kansas
- Safety Advocacy Finance and Education (SAFE)
- Emergency Solutions Grant Recipients (ESG)
- Southeast Kansas Services Emergency Assistance (EA) Ministries
- Wesley House
- City of Pittsburg Community Development and Housing
- Utility Companies:
  _____
  _____
- Home Sweet Home Ministries
- Crawford County Mental Health
- SEK Mental Health
- Four County Mental Health
- TFI Family Services
- Department for Children and Families (DCF)
- Hope Unlimited
- Safehouse
- Community Health Center of Southeast Kansas (CHCSEK)
- Probation/Parole Officer:
  _____
- Other(s):
  _____
  _____

Information to be Shared

This Authorization for Disclosure of Confidential Information authorizes the following types of information to be shared between the agencies listed above:

- Coordinated Entry Assessment Scores
- Program intake and enrollment information
- Potential barriers to obtaining and maintaining housing including criminal background, mental/physical disabilities, living conditions, household composition, and household income.
- Contact information
- Established goals, outcomes, and housing stabilization plan
- Status of assistance requests and applications
- Status of requested paperwork and/or documents for program participation
- Protected health information

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present, or future physical or mental health or condition. I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The undersigned acknowledge that he/she is aware that certain information that he/she is consenting to release is confidential and protected by Federal and State law. The undersigned acknowledge that upon signing this consent that they are waiving their rights under these laws and that they are aware of the specific protections that they are afforded, or they are waiving their right to be informed of the specific provisions of these laws.

This authorization expires one year from the date of signature, unless revoked in writing prior to the end of one year. This authorization may be revoked at any time.

Printed Name	Signature	Date

STUDENT STATUS AFFIDAVIT

Applicant/Resident _____ Date _____

Are you a student at an institution of higher education? _____ Yes _____ No
If NO, skip Questions 1 - 10 and sign below.
If YES, answer Questions 1 - 10 below:

	YES	NO
1. Are you a graduate or professional student?	____	____
2. Are you disabled?	____	____
If yes, were you receiving Section 8 assistance as of November 30, 2005	____	____
3. Are you at least 24 years of age?	____	____
4. Are you a veteran of the United States military?	____	____
5. Are you married?	____	____
6. Do you have a dependent child?	____	____
7. Do you have dependents other than a child or spouse?	____	____
8. Were you an orphan or a ward of the court through the age of 18?	____	____
9. Will you be living with your parents?	____	____
If no: Are your parents receiving or eligible to receive Section 8 assistance?	____	____
Are you claimed as a dependent on your parent's tax return?	____	____
10. Are you receiving any financial assistance to pay for your education?	____	____

If yes, please list the sources of financial assistance:

_____

_____

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD 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 this verification form is restricted to the purposes cited above. Any person who knowingly or willingly 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 or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208(a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

Signature of Applicant/Resident: _____ Date: _____

ZERO/ LITTLE INCOME QUESTIONNAIRE

Tenant Name:

Social Security Number:

Address: City: State: Zip Code:

To claim zero income in the HUD Section 8 housing program you must have no income from any source except student financial aid, resident service stipends, adoption assistance payments, earned income for full time students **EXCEPT THE HEAD OF HOUSEHOLD OR SPOUSE,** adult foster care payments, compensation from State or local job training programs, and training of resident management staff, property tax rebates, homecare payments for developmentally disabled children or adult family members, and deferred periodic payments of supplemental security income and social security benefits that are received in a lump sum.

Please **fully complete all questions below**, sign and date and return to our office, this form is **REQUIRED** even if you are not claiming zero income. Each adult (18+) household member must complete a separate form.

I, as head of household, or any adult member (over the age of 18) living in the above unit, receive income from the following sources: (Provide documentation for all items marked "YES") **ANSWER ALL EITHER "YES" or "NO"**

Income:	YES	NO	Income:	YES	NO
1. Wages, including part time, commissions, & overtime			13. Food Assistance (SNAP, Food Stamps)		
2. Cash Benefits from DCF (previously SRS)			14. Salary from family-owned business		
3. Social Security Income, including payments received for children.			15. Net Income from Business		
4. SSI Benefits			16. Annuities		
5. Pensions			17. Insurance Policies		
6. Interest or Dividend Income			18. Retirement Funds		
7. V.A. Benefits			19. Workers Compensation		
8. Baby-sitting Income			20. Severance Payments		
9. Recurring Periodic Gifts			21. Alimony		
10. Fees			22. Child Support		
11. Tips			23. Winnings paid in periodic Payments		
12. Bonuses			24. Rent Income of any type		

You must provide answers to all the following questions.

Are your utilities on? If so, who pays for the utilities?

_____

How will you pay for food and clothing?

_____

How will you pay for medical expenses?

_____

How will you pay for transportation expenses?

_____

Do you have pets? If yes, how many? How will you pay for food and veterinarian needs?

_____

Besides necessities, how will you pay for cell phone bills, cosmetology needs, and other non-necessities?

_____

By signing, I understand that if I claim zero income for housing assistance, I must complete this form **EVERY TIME I RECEIVE IT** and return it to the housing office. Failure to do so will result in my losing my housing assistance. I agree to notify the housing agency **IN WRITING IMMEDIATELY** if the above information changes. I certify that the above information is correct. Any false statements will result in my application being dropped from the waitlist OR losing my housing assistance.

_____

Signature Date

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the U.S. as to any matter within its jurisdiction.

Custody/Child Support & Alimony Affidavit

Applicant/Tenant:_____

This form verifies the receipt/non-receipt of child support and custody for the following children:

_____ _____ _____

_____ _____ _____

Name of Absent Parent (please use a separate form for each Absent Parent):_____

Will the above child/children live with you in the unit at least 50% of the time? ☐ Yes ☐ No

Was there a legal marriage to the other parent? ☐ Yes ☐ No

If Yes, please submit a copy of the divorce decree, separation agreement or other document outlining custody arrangements.

If No, is there a court order for child support? ☐ Yes ☐ No

If Yes, provide court order # and a copy of the court order:_____

If No, provide documentation that outlines custody arrangements.

---

1. ☐ I have a court order for: ☐ Alimony ☐ Child Support

KPC PIN#_____ **Call 1-877-572-5722 to get your PIN#**

(If you do not have a court order, skip to number 2)

Do you receive any payments? ☐ Yes ☐ No

If No, provide reason why:_____

If Yes, do you receive the full court ordered amount? ☐ Yes ☐ No

If Yes, Amount $_____ **every ☐ week / ☐ month / ☐ year**

Provide Backup Documentation, if not available why?_____

If No, Amount $_____ **every ☐ week / ☐ month / ☐ year**

(Divorce decree, separation statement, child support enforcement order, payment sheet from an enforcement agency and legal attempts to collect is required. If not obtained, the full amount of the original court order must be used)

---

2. ☐ I do not have a court order for: ☐ Alimony ☐ Child Support

Do you receive any payments? ☐ Yes ☐ No

If No, provide reason for no court order:_____

If Yes, Amount $_____ **every ☐ week / ☐ month / ☐ year**

(Provide Documentation)

I certify under the penalty of perjury that all information provided for the purpose of completing this form is true and complete to the best of my knowledge and belief. I understand that willful misrepresentation of any information provided herein constitutes fraud and may be delt with in a Court of Law.

_____ _____

Applicant/Tenant Signature Date SEK-CAP Staff Signature Date

Note: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department of Agency of the United States as to any matter within its jurisdiction.