

## Tenant Based Rental Assistance (TBRA) Applications Accepted Beginning June 25<sup>th</sup>, 2026

*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.*

### **Step 1**

Complete the TBRA Application Packet, including gathering all supporting documentation (ex. IDs, Birth Certificates, SS Cards, Benefit Letters, Paystubs, Checking/Savings Account Information, Other Asset Information (PayPal, Cash App, Zelle, Chime, etc.), etc.)

### **Step 2**

Obtain a Homeless Certification **completed by an Agency Partner** (list included in packet) and return with TBRA Application Packet

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

**\*MUST USE THE SEK-CAP HOMELESS CERTIFICATION FORM THAT IS INCLUDED IN THE PACKET, ALL OTHERS WILL BE REJECTED\***

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

Fax: (620)724-8741

Email: [housinginfo@sek-cap.com](mailto:housinginfo@sek-cap.com)

If you need assistance completing the required paperwork call our office at (620)724-8204

# TBRA Income Limits

## Effective 05/01/2026

# of Household Members	<i>Income Limits Set at 50% of Area Median Income (AMI)</i>				
	<b>Allen County</b>	<b>Bourbon County</b>	<b>Linn County</b>	<b>Neosho County</b>	<b>All Other Counties*</b>
1	31,150	30,300	39,700	31,200	30,000
2	35,600	34,600	45,450	35,650	34,300
3	40,050	38,950	51,050	40,100	38,600
4	44,500	43,250	56,700	44,550	42,850
5	48,100	46,750	61,250	48,150	46,300
6	51,650	50,200	65,800	51,700	49,750
7	55,200	53,650	70,350	55,250	53,150
8	58,750	57,100	74,850	58,850	56,600

**\*ALL OTHER COUNTIES INCLUDES CHAUTAUQUA, CHEROKEE, CRAWFORD, ELK, LABETTE, MONTGOMERY, WOODSON, AND WILSON COUNTIES.**

## Tenant Based Rental Assistance (TBRA)

### Qualification Requirements

This is not a full list of documentation or information required for the program.  
Please see the application packet for all required documentation and information.  
Additional information might be required as well.  
Please see the Administrative Plan for a complete list of eligibility requirements.

#### **Homeless Certification**

One of the following ***must*** apply (at application) to be eligible for the TBRA program.

1. Applicant has a primary night-time residence that is a public or private place not meant for human habitation (e.g., car, park, abandoned building, street/sidewalk)
2. Applicant is living in a publicly or privately operated shelter designated to provide temporary living arrangements (e.g., congregate shelters, transitional housing, hotels/motels paid for by charitable organizations)
3. Applicant is 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.
4. Applicant is fleeing, or attempting to flee, domestic violence; **AND**  
Has no other residence; **AND**  
Lacks the resources or support networks to obtain other permanent housing
5. Applicant is an unaccompanied youth between the ages of 18-24, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
  - a. Are defined as homeless under other listed federal statutes; **AND**
  - b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to application; **AND**
  - 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

## **Income Limits**

Household income cannot exceed 50% of Area Median Income (AMI)

# of Household Members	Income Limits Set at 50% of Area Median Income (AMI)				
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1	31,150	30,300	39,700	31,200	30,000
2	35,600	34,600	45,450	35,650	34,300
3	40,050	38,950	51,050	40,100	38,600
4	44,500	43,250	56,700	44,550	42,850
5	48,100	46,750	61,250	48,150	46,300
6	51,650	50,200	65,800	51,700	49,750
7	55,200	53,650	70,350	55,250	53,150
8	58,750	57,100	74,850	58,850	56,600

\*ALL OTHER COUNTIES INCLUDES CHAUTAUQUA, CHEROKEE, CRAWFORD, ELK, LABETTE, MONTGOMERY, WOODSON, AND WILSON.

## **Criminal History / Other**

- *Mandatory Denial of Assistance*
  - Any member of the household has been evicted from federally assisted housing in the last 3 years for drug related criminal activity
  - Any member of the household is currently engaged in the use of illegal drugs
    - Currently engaged is defined as in the previous 6 months
  - Reasonable cause to believe that any household member's current use or pattern of use of illegal drugs, or current abuse or pattern of abuse of alcohol, may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents.
  - Any household member has ever been convicted of drug-related criminal activity for the production or manufacture of methamphetamine.
  - Any household member is subject to a lifetime registration requirement under a state sex offender registration program.
  
- *SEK-CAP Established Denials*
  - Any member of the household that has been convicted in the last 3 years of any drug related criminal activity, violent criminal activity, or criminal activity that may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents or persons residing in the immediate vicinity.
    - Verification from an approved 3<sup>rd</sup> party that the family member has not engaged in this behavior for at least the previous 6 months could result in an application not being denied for this reason.
  - Failure to provide information determined to be necessary in the administration of the program.
  - Failure to provide complete and true information.
  - Any family member has been evicted from federally assisted housing in the last 3 years.
  - Any family member has committed fraud, bribery, or any other corrupt or criminal act in connection with any federal housing program.
  - Any family who owes rent or other amounts to any PHA and has not paid back the debt or is not current on a repayment agreement.
  - Any family member has engaged in or threatened violent or abusive behavior toward PHA personnel.



Housing Services  
401 N. Sinnet / P.O. Box 128  
Phone: (620)724-8204  
Fax: (620)724-8741  
Email: [housinginfo@sek-cap.com](mailto: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 valid Photo ID for all adult household members
- Copy of Social Security Cards (or other approved documentation) 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 **(REQUIRED!!!)**

- Homeless Certification** – Completed by an Agency Partner (list provided)  
**\* MUST USE THE SEK-CAP FORM THAT IS INCLUDED\***

## 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 3<sup>rd</sup> 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 a separate form.
  - 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 a separate 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

<b>Allen County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	Domestic Violence Victims Only
Humanity House	620-380-6664	X	All Welcome
Thrive Allen County	620-365-8128	X	All Welcome

<b>Bourbon County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only
SEK Mental Health Center	620-223-5030	X	All Welcome
TFI Family Services	620-371-8724	X	Clients Only

<b>Chautauqua County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment

<b>Cherokee County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only

<b>Crawford County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only
Crawford County Mental Health	620-231-5130	X	All Welcome
Family Response Advocate	620-687-5668	X	Clients Only
Building Health, Inc.	620-240-5661	X	All Welcome
City of Pittsburg	620-232-1210	X	All Welcome Inside Pittsburg
Salvation Army	620.231.0415	X	All Welcome

<b>Elk County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment

## TBRA Partner Agencies

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

<b>Linn County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only
SEK Mental Health Center	913-352-8214	X	All Welcome
TFI Family Services	620-371-8724	X	Clients Only

<b>Montgomery County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only
CHC of SEK (Coffeyville)	620-251-4300	X	Clients Only

<b>Neosho County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	Domestic Violence Victims Only

<b>Wilson County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Safehouse Crisis Center	620-231-8692	X	Domestic Violence Victims Only

<b>Woodson County</b>			
Agency	Phone Number	Homeless Certification	Referral Type
Catholic Charities	620-235-0633	X	All Welcome by Appointment
Hope Unlimited Inc.	620-365-7566	X	Domestic Violence Victims Only

**Tenant Based Rental Assistance (TBRA) – 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 night-time 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 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

\_\_\_\_\_  
Applicant Printed Name

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referral Rep – Printed Name

\_\_\_\_\_  
Referral Rep – Signature

\_\_\_\_\_  
Date

**SEK-CAP USE ONLY!**

Date Received: \_\_\_\_\_

Time Received: \_\_\_\_\_

Staff Initials: \_\_\_\_\_



## HOUSING ASSISTANCE APPLICATION UPDATE / RECERTIFICATION

**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			H = Hispanic N = Non Hispanic
						Circle <u>all</u> that apply			Circle One
						Race			Ethnic
						B	W	A	H
						AI	H	M	N
						B	W	A	H
						AI	H	M	N
						B	W	A	H
						AI	H	M	N
						B	W	A	H
						AI	H	M	N
						B	W	A	H
						AI	H	M	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

## INCOME AND/OR BENEFIT SOURCES

**YOU MUST REPORT INCOME RECEIVED BY ANY HOUSEHOLD MEMBER.**

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

**CERTIFICATION**

- Name every state you and members of your household have resided in as adults:

\_\_\_\_\_

- Are you or any member 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 three (3) years?

YES  NO Year(s): \_\_\_\_\_

- Have you or any member of your household been arrested for ANY REASON in the past three (3) years?  YES  NO

If YES, is there a court case pending?  YES  NO

WHO:				
CHARGE:				
DATE:				

*\*COMPLETE ON SEPARATE SHEET OF PAPER IF NEEDED\**

- Have you or any member of your household been convicted for ANY criminal activity (including drugs) in the past three (3) years?  YES  NO

WHO:				
CHARGE:				
DATE:				

*\*COMPLETE ON SEPARATE SHEET OF PAPER IF NEEDED\**

**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 of Head of Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse or other Adult Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of other Adult Member

\_\_\_\_\_  
Date

**If you believe you have been discriminated against you may call the Fair Housing and 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.**

# 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)

Health 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 1974, 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: \_\_\_\_\_

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.

<b>Applicant Name:</b>	
<b>Mailing Address:</b>	
<b>Telephone No:</b>	<b>Cell Phone No:</b>
<b>Name of Additional Contact Person or Organization:</b>	
<b>Address:</b>	
<b>Telephone No:</b>	<b>Cell Phone No:</b>
<b>E-Mail Address (if applicable):</b>	
<b>Relationship to Applicant:</b>	
<b>Reason for Contact:</b> (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	
<b>Commitment of Housing Authority or Owner:</b> 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.	
<b>Confidentiality Statement:</b> The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
<b>Legal Notification:</b> 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. 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

**\* SEPARATE FORM REQUIRED FOR ALL HOUSEHOLD MEMBERS**

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 18.)

\_\_\_\_\_  
**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



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:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>- Southeast Kansas Community Action Program (SEK-CAP) - All Programs</li> <li>- Catholic Charities of Southeast Kansas</li> <li>- Safety Advocacy Finance and Education (SAFE)</li> <li>- Emergency Solutions Grant Recipients (ESG)</li> <li>- Southeast Kansas Services Emergency Assistance (EA) Ministries</li> <li>- Wesley House</li> <li>- City of Pittsburg Community Development and Housing</li> <li>- Utility Companies:<br/>_____</li> <li>- _____</li> <li>- Home Sweet Home Ministries</li> </ul> | <ul style="list-style-type: none"> <li>- Crawford County Mental Health</li> <li>- SEK Mental Health</li> <li>- Four County Mental Health</li> <li>- TFI Family Services</li> <li>- Department for Children and Families (DCF)</li> <li>- Hope Unlimited</li> <li>- Safehouse</li> <li>- Community Health Center of Southeast Kansas (CHCSEK)</li> <li>- Probation/Parole Officer:<br/>_____</li> <li>- Other(s):<br/>_____</li> <li>- _____</li> </ul> |
|--|--|

**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

**CONFIDENTIAL (FOR PROFESSIONAL USE ONLY)**

This information has been disclosed to you from confidential records by Federal Law.  
Federal regulations prohibit you from any further disclosure.  
(42 CFR, Part 2)

## 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:**

	<u>YES</u>	<u>NO</u>
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? <b>If yes, please list the sources of financial assistance:</b> _____ _____	_____ _____	_____ _____

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 \_\_\_\_\_

## 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.**

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**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)

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**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)

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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 dealt 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.