Section 8 Change form to Add Family Member to Household

Be sure to answer all questions, leaving no blanks. If the question does not apply, write none.

Head of the Household: _____Phone #_____

Address: _____ Msg Phone # _____
Street City Zip

REQUEST TO ADD MEMBERS TO HOUSEHOLD:

_____
New members current address Street City State Zip

Complete the information for all adults and children being added to your assisted unit (List adults first, then children). Provide social security cards, birth certificates and photo ID.

NEW HOUSEHOLD MEMBER:

1. Last Name (Include Jr, Sr, etc.)	**2. First Name**	**3. M.I.**	**4. Birth Date**	**5. Sex** M ☐ F ☐	**6. Relation**
8. Social Security Number	**9. Place of Birth**	**10. Race** ☐ White ☐ Black or African American ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander			**11. Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino
12. Are you a student? Yes ☐ **No** ☐ Full-Time ☐ Include a copy of School Schedule Part-Time ☐ Include a copy of School Schedule	**13. Do you receive Financial Aid?** Yes ☐ Include a copy of the Award Letter No ☐	**14. Name and Address of School**			
15. If Minor Child: Does this person live in the home full-time? Yes ☐ No ☐					

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15. If Minor Child: Does this person live in the home full-time? Yes ☐ No ☐					

If you or anyone in your family is a person with disabilities, and you require an accommodation in order to fully utilize our programs and services, please contact the HACB office.

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Contact Information:

If unable to contact you, please list name and phone number of contact person:

Name	Phone	Relationship

Criminal History:

It is important you answer these questions fully, accurately, and honestly. Criminal history does not necessarily keep you from obtaining housing assistance. Attach additional paper if needed.

Has the new member ever been convicted of a drug-related crime or violent crime? **Yes** ☐ **No** ☐

If yes, list name(s): _____

Date of conviction: _____ City _____ State _____

Is any new member of the household required to register as a sex offender? **Yes** ☐ **No** ☐

If yes, list name(s): _____

Date of conviction: _____ City _____ State _____

While living in federally assisted housing, has the new member ever been convicted of manufacturing or producing methamphetamine? **Yes** ☐ **No** ☐

If yes, list name(s): _____

Date of conviction: _____ City _____ State _____

Has any new household member ever been or is currently on parole or probation? **Yes** ☐ **No** ☐

If yes, list name(s): _____

Dates of parole/probation: _____ to _____ City _____ State _____

Parole/probation officer's name: _____ Parole/probation officer's phone: _____

In what state did the offense resulting in parole/probation occur? _____

What charges resulted in parole/probation? _____

General Information:

Has any new household member lived in a government-subsidized unit such as Public Housing/Section 8? **Yes** ☐ **No** ☐

If yes, please explain: _____

Has any new household member ever committed fraud in federally-assisted programs or been required to repay money for misrepresenting information for such housing programs? **Yes** ☐ **No** ☐

If yes, please explain: _____

Has any new household member ever been evicted from Public Housing? **Yes** ☐ **No** ☐

If yes, please explain: _____

INCOME

Do you or any member of the family receive any of the following or expect to receive any of the following during the next twelve (12) months? Answer every question Yes or No. Income includes all money or contributions from any and all sources paid to you or on behalf of any family member.

Yes	No		Who Receives?	Amount
☐	☐	Retirement Funds or Pension?	_____	
☐	☐	Death Benefits?	_____	
☐	☐	Social Security?	_____	
☐	☐	SSI?	_____	
☐	☐	Veteran's Benefits?	_____	
☐	☐	CalWorks or CalFresh?	_____	Cash Aid $_____
☐	☐	Are CalWorks benefits being sanctioned?	_____	CalFresh Amount $_____
☐	☐	Child Support?	_____	
☐	☐	Spousal Support/Alimony?	_____	
☐	☐	Financial Aid?	_____	
☐	☐	Unemployment Benefits?	_____	
☐	☐	Workers Comp/State Disability?	_____	
☐	☐	Foster Care Payments?	_____	
☐	☐	Income from Insurance Policies?	_____	
☐	☐	Income from annuity or other investment?	_____	
☐	☐	Interest, Dividends or other income from Real or Personal Property?	_____	
☐	☐	Self-Employment? Please provide a copy of last year's tax return		
		Who receives income? _____	Type of Business_____	
		Business Address _____ (Street) (City) (State) (Zip)		
☐	☐	Employment? Please complete Earnings/Wages section.		

Do you regularly receive gifts or non-cash contributions from anyone outside the household? For example:

YES	NO	
☐	☐	Rent or utilities _____
☐	☐	Cash _____
☐	☐	Groceries (Do Not Include Food Stamps) _____
☐	☐	Car payments, gas, health insurance, medical bills _____
☐	☐	Miscellaneous Household Supplies or any other items provided? _____

If yes, provide name and address of person. _____

EARNINGS/WAGES SECTION

Indicate below all wages, salaries, tips or commissions, overtime, bonuses, or other compensation for personal services from any and all employers, including Military Pay. **Must provide your last 3 months of pay stubs or if seasonal provide copy of last year's tax return.**

Who receives income? _____ Employer_____

Employer's Address _____

City _____ Zip Code _____ Employer's Phone Number _____

Paid?
- ☐ Weekly
- ☐ Bi-Weekly (every 2 weeks)
- ☐ Semi-Monthly (twice monthly)
- ☐ Monthly
- ☐ Other (explain): _____

Hours worked per week? _____ Hourly Rate? _____

Average overtime hours per week? _____ Average tips/commissions per week? _____

Who receives income? _____ Employer_____

Employer's Address _____

City _____ Zip Code _____ Employer's Phone Number _____

Paid?
- ☐ Weekly
- ☐ Bi-Weekly (every 2 weeks)
- ☐ Semi-Monthly (twice monthly)
- ☐ Monthly
- ☐ Other (explain): _____

Hours worked per week? _____ Hourly Rate? _____

Average overtime hours per week? _____ Average tips/commissions per week? _____

Who receives income? _____ Employer_____

Employer's Address _____
Street City State Zip

Employer's Phone Number _____

Paid?
- ☐ Weekly
- ☐ Bi-Weekly (every 2 weeks)
- ☐ Semi-Monthly (twice monthly)
- ☐ Monthly
- ☐ Other (explain): _____

Hours worked per week? _____ Hourly Rate? _____

Average overtime hours per week? _____ Average tips/commissions per week? _____

ASSETS

Do you or any family member have any of the following Assets? Check Yes or No for each Type of Asset. Attach a separate sheet if needed. **Please attach a copy of the most recent statement for each account.**

Type of Asset	Do you Have?	Family Member	Name of Bank, Brokerage, or Company	Value or Balance
Checking	☐ **Yes** ☐ **No**			
Savings	☐ **Yes** ☐ **No**			
Money Market	☐ **Yes** ☐ **No**			
Stocks/Bonds Annuities/CD	☐ **Yes** ☐ **No**			
IRA/KEOGH/ Retirement	☐ **Yes** ☐ **No**			
Trust	☐ **Yes** ☐ **No**			
Life Insurance	☐ **Yes** ☐ **No**			
Real Property (real estate)	☐ **Yes** ☐ **No**			
Other Capital Investments	☐ **Yes** ☐ **No**			

Yes No

☐ ☐ Have you or any family member sold or given away of any assets for less than fair market value in the past two (2) years?

If yes, date disposed? _____ Value? _____, Amount Received? _____

☐ ☐ Are any assets held jointly with another person?

If yes, provide their name and address._____

EXPENSES

Medical Expenses: NONE ☐

Is the Head of Household, Spouse, or Co-Head Elderly (62 years or older)? Yes ☐ No ☐
Is the Head of Household, Spouse, or Co-Head Disabled? Yes ☐ No ☐
Is any other member of your household disabled? Yes ☐ No ☐
If yes, whom: _____

FOR HEAD OF HOUSEHOLD, SPOUSE, OR CO-HEAD THAT IS ELDERLY OR DISABLED:

List the medical expenses anticipated to be paid or incurred for each family member over the coming twelve (12) months. Medical expenses include items such as prescription/non-prescription medicines prescribed by a doctor, health insurance premiums, regular payments on past-due medical bills, etc. *(See IRS Publication 502 for more information on qualifying medical expenses. This publication may be found at www.irs.gov.)*

Please list all out of pocket medical expenses below. If you have expenses not listed, put them in "other". If there is not enough room please attach an additional piece of paper listing names, mailing addresses and phone numbers or your medical providers.

Expense	Family Member	Complete Mailing Address	Phone Number	$ Amount Paid
Medicare				
Other Medical Insurance				
Doctor's Office				
Pharmacy				
Pharmacy				
Other				

DISABILITY ASSISTANCE EXPENSES:

Do you pay a care attendant for any family member(s) with disabilities that is necessary to permit that person or someone else in the family to work? Yes ☐ No ☐

If yes, please provide the following:

Household Member	Care Attendant Name	Care Attendant Address	Care Attendant Telephone Number

What is the monthly cost to you for the care attendant? $_____

Child Care Expenses: NONE ☐

Do you pay for child care to: ☐ Work? ☐ Look for Work? ☐ Attend School?

Do you receive help with childcare expenses from any agencies? Yes☐ No ☐

If so, which agency? _____

If so, what is your co-pay amount? $_____ Do you pay above your co-pay amount? Yes ☐ No ☐

Caseworker's Name _____ Case Workers Phone # _____

Childcare provider's Name _____ Phone # (_____)_____

Mailing Address _____

WARNING!!! TITLE 18, SECTION 1001, OF THE UNITED STATES CODE, STATE THAT PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO A DEPARTMENT OF AGENCY OF THE UNITED STATES.

I declare under the penalty of perjury that the information included on these forms (including any accompanying forms) has been examined by me and to the best of my knowledge and belief is true, correct, and complete.

I / We certify that the information provided to the Housing Authority of the County of Butte on Household composition, income, net family assets, allowance, and deductions is accurate and complete to the best of my / our knowledge and belief. **I have not omitted, misstated, or withheld facts pertaining to the Household's Income or Persons living in the unit. I understand that it is my responsibility to report to the Housing Authority, any changes in income, assets, and number of persons living in the unit, whenever they occur. I have been made aware of the Housing Programs requirements and prohibitions.** I / We understand that false statements or information are punishable under Federal Law. I / We also understand that false statements or information are grounds for termination of Housing Assistance and termination of tenancy.

_____		_____	
Signature of Head of Household	**Date**	**Signature of Spouse/Other Adult**	**Date**
_____		_____	
Signature of Other Adult	**Date**	**Signature of Other Adult**	**Date**

CERTIFICATION OF HACB REPRESENTATIVE

I certify that I have reviewed all questions and answers on this form provided by the Head of Household to ensure that each question was answered and verifications were received.

_____ _____

Signature of HACB Representative Date

If you or anyone in your family is a person with disabilities, and you require an accommodation in order to fully utilize our programs and services, please contact the HACB office.