

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: _____
Street
City
Zip
Msg Phone # _____

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 <input type="checkbox"/> F <input type="checkbox"/>	6. Relation
8. Social Security Number	9. Place of Birth	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			11. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
12. Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/> Full-Time <input type="checkbox"/> Include a copy of School Schedule Part-Time <input type="checkbox"/> Include a copy of School Schedule		13. Do you receive Financial Aid? Yes <input type="checkbox"/> Include a copy of the Award Letter No <input type="checkbox"/>		14. Name and Address of School	
15. If Minor Child: Does this person live in the home full-time? Yes <input type="checkbox"/> No <input type="checkbox"/>					

NEW HOUSEHOLD MEMBER:

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

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.

NEW HOUSEHOLD MEMBER:

1. Last Name (Include Jr, Sr, etc.)	2. First Name	3. M.I.	4. Birth Date	5. Sex M <input type="checkbox"/> F <input type="checkbox"/>	6. Relation
8. Social Security Number	9. Place of Birth	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			11. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
12. Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/> Full-Time <input type="checkbox"/> Include a copy of School Schedule Part-Time <input type="checkbox"/> Include a copy of School Schedule		13. Do you receive Financial Aid? Yes <input type="checkbox"/> Include a copy of the Award Letter No <input type="checkbox"/>		14. Name and Address of School	
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8. Social Security Number	9. Place of Birth	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			11. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
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8. Social Security Number	9. Place of Birth	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			11. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
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8. Social Security Number	9. Place of Birth	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			11. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
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Contact Information:

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

Name	Phone	Relationship
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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
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Funds or Pension?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Death Benefits?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security?	_____
<input type="checkbox"/>	<input type="checkbox"/>	SSI?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Benefits?	_____
<input type="checkbox"/>	<input type="checkbox"/>	CalWorks or CalFresh?	_____ Cash Aid \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Are CalWorks benefits being sanctioned?	_____ CalFresh Amount \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Child Support?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spousal Support/Alimony?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Financial Aid?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Benefits?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Workers Comp/State Disability?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Foster Care Payments?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Income from Insurance Policies?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Income from annuity or other investment?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Interest, Dividends or other income from Real or Personal Property?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Self-Employment? Please provide a copy of last year's tax return	
		Who receives income? _____	Type of Business _____
		Business Address _____	
		Street	City
		State	Zip
<input type="checkbox"/>	<input type="checkbox"/>	Employment? Please complete Earnings/Wages section.	

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

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Rent or utilities _____
<input type="checkbox"/>	<input type="checkbox"/>	Cash _____
<input type="checkbox"/>	<input type="checkbox"/>	Groceries (Do Not Include Food Stamps) _____
<input type="checkbox"/>	<input type="checkbox"/>	Car payments, gas, health insurance, medical bills _____
<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Savings	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Money Market	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Stocks/Bonds Annuities/CD	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
IRA/KEOGH/ Retirement	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Trust	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Life Insurance	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Real Property (real estate)	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
Other Capital Investments	<input type="checkbox"/> Yes			
	<input type="checkbox"/> 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.