**HOUSING CHOICE VOUCHER INITIAL APPLICATION**

**MESQUITE HOUSING OFFICE**

**PHONE 972.216.6424 FAX 972.216.6429**

The Mesquite Housing Division takes appropriate steps to ensure effective client communication. If you or a member of your household requires assistance or a reasonable accommodation in completing the application and/or meeting attendance, please contact Aurora Bueno at 972-216-6427 prior to the meeting date.

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please Print Phone Number Email Address

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

1. **Household Composition –** Please list all persons who will be living as part of the household. Use additional pages if necessary.

 \*Participants are not required to disclose being disabled. However, benefits for disabled household members cannot be provided unless the participant discloses being disabled.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Household Member Name First Mi Last | Social Security Number | Relation to Head of Household | Sex | Race | Ethnicity (Hispanic or Non-Hispanic) | Birth Date (Including Year) | Current Age | US Citizen (Y/N) | Disabled (Y/N)\* | First / Last Name of Absent Parent(s) (if under age 18 and one or more parent(s) are absent from household) |
|  |  | HEAD OF HOUSEHOLD |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
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1. [ ]  Yes [ ]  No Are you married (legal or common-law)? If yes, list name of spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *If married (legal or common-law), please answer the following question:*

[ ]  Yes [ ]  No Does your spouse live with you? If no, where does your spouse live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If your spouse does not live with you, answer the following questions:*

[ ]  Yes [ ]  No Is your spouse temporarily absent from your home due to employment, illness, incarceration, etc?

[ ]  Yes [ ]  No Are you separated from your spouse? If yes, since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. [ ]  Yes [ ]  No Are you single, divorced, or widowed?

c. [ ]  Yes [ ]  No Are any household members students? If yes, please list family members below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME OF STUDENT** | **AGE** | **NAME OF SCHOOL** | **CITY/STATE** | **FULL TIME** | **PART TIME** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**2. Child Care Expenses:**

1. [ ]  Yes [ ]  No Do you pay out of pocket for Child Care while you work, attend school, or seek employment?

If yes, to whom are expenses paid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much is paid per month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of the Child Care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. [ ]  Yes [ ]  No Does any organization help to pay for child care (ex. CCMS)?

If yes, which organization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much is reimbursed/paid by the organization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Income:** Please indicate by checking “yes” or “no” if any of these types of income are received by any members of the household. List ALL income earned or received by everyone living in the household, regardless of age. Please list the full amount of income before any deductions.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Income | Yes | No | Name of Family Member Receiving Income | Source | Amount | Frequency (hourly, weekly, bi-weekly, monthly, etc) | Date Income Started |
| Wages or Employment |  |  |  | Employer: | Phone # of Employer: |  |  |  |
| Employer Address: | Fax # of Employer: |
|  | Employer: | Phone # of Employer: |  |  |  |
| Employer Address: | Fax # of Employer: |
| Military Income |  |  |  |  |  |  |  |
| Self-Employment Income  |  |  |  | (ex. lawn care, hair stylist, baby sitting, adult care, etc) |  |  |  |
| Temporary/Sporadic Income |  |  |  |  |  |  |  |
| Cyclical or Seasonal Work |  |  |  |  |  |  |  |
| Unemployment Benefits |  |  |  |  |  |  |  |
| Child Support |  |  | Child’s Name: | CIN :  |  STATE: | Non-Custodial Parent Name (First and Last): |  |  |  |
| Child’s Name: | CIN :  |  STATE: | Non-Custodial Parent Name (First and Last): |  |  |  |
| Pension/Retirement |  |  |  | Company/Organization: | Phone #: |  |  |  |
| Social Security |  |  | Name of Family Member(s) |  |  |  |
| SSI |  |  | Name of Family Member(s) |  |  |  |
| TANF |  |  | Name of Family Member(s) |  |  |  |
| **Income, continued** – List ALL income earned or received by everyone living in the household, regardless of age.  |
| Type of Income | Yes | No | Name of Family Member Receiving Income | Source | Amount | Frequency (hourly, weekly, bi-weekly, monthly, etc) | Date Income Started |
| Alimony |  |  | Name of Family Member(s) |  |  |  |  |
| Food Stamps |  |  | Name of Family Member(s) |  |  |  |  |
| Veterans Admin. |  |  |  |  |  |  |  |
| Regular Contributions or Gifts  |  |  |  | (ex. Someone helps with bills, buying food, buying items such as cleaning products or hygiene items, etc) |  |  |  |
| Student Financial Assistance  |  |  |  | (ex. Scholarships, Grants, Work Study, etc.) |  |  |  |
| Lump Sum Payments |  |  |  |  |  |  |  |
| Workers Compensation |  |  |  |  |  |  |  |

**4.** **Assets:** Do any household members have assets or receive income from assets? Check “yes” or “no” and complete all that apply to the household:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Type of Asset | Yes | No | Name of Family Member with Asset | Bank Name (Location of Asset if not held in a Bank) | Account No. | Approx. Value of Asset |
| Checking Account |  |  |  |  |  |  |
| Savings Account |  |  |  |  |  |  |
| Debit Card |  |  |  |  |  |  |
| Certificate(s) of Deposit |  |  |  |  |  |  |
| Trusts |  |  |  |  |  |  |
| IRA, 401(k), or other similar retirement savings |  |  |  |  |  |  |
| **Assets, continued:** Do any household members have assets or receive income from assets? Check “yes” or “no” and complete all that apply to the household: |
| Type of Asset | Yes | No | Name of Family Member with Asset |  Bank Name (Location of Asset if not Held in a Bank) | Approx. Value of Asset |
| Stocks/Bonds |  |  |  |  |  |
| Company Retirement or Pension Fund |  |  |  |  |  |
| Insurance Settlements |  |  |  |  |  |
| Real Estate |  |  |  |  |  |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

1. [ ]  Yes [ ]  No Has any asset been given away or sold for less than its fair market value in the past 2 years?

 If yes, specify asset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the market value? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How much interest or other income have you received from assets in the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **General Medical or Disability Information**
	1. [ ]  Yes [ ]  No Does anyone in your household require assistance or special accommodations *from the Housing Office* because of a disability?

If yes, please specify household member(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. [ ]  Yes [ ]  No Do any Elderly or Disabled household member(s) require a Live-In Aid?

 If yes, please specify household member(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. [ ]  Yes [ ]  No Do you pay for attendant care or auxiliary apparatus’ for a disabled member of the household in order to enable them, or another family member, to work?

If yes, please specify household member(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Medical or Disability Expenses – *Complete this section ONLY if the Head of Household or Spouse is disabled or 62 years of age or older.***

a. [ ]  Yes [ ]  No Do you any out of pocket medical expenses that will not be reimbursed by insurance, Medicare, Medicaid, or another outside source? If yes, please list all medical expenses the family anticipates paying during the next 12 months that will NOT be reimbursed by insurance or another outside source. DO NOT include life or burial insurance premiums.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Expense |  Address |  Phone # |  Fax # | Anticipated Monthly Amount |
| Medical Insurance(s) |  |  |  | $ |
| Prescription Medication(s)Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | $ |
| Copayment(s) or other expensesDoctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | $ |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

**7. Additional Questions:**

* 1. [ ]  Yes [ ]  No Have you ever lived in Public Housing, participated in a Housing Choice Voucher Program (Section 8) through another agency, or lived in any other government subsidized housing? If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. [ ]  Yes [ ]  No Are you or any other household member(s) a current abuser or addict of a controlled substance, or currently engaging in the illegal use of drugs and/or abuse of alcohol? If yes, please state member(s) name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. [ ]  Yes [ ]  No Have you or any other household member(s) ever been ARRESTED or CONVICTED for the illegal manufacture or distribution of a controlled substance? If yes, please state member(s) name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the charge or conviction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What county and/or state? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 d. [ ]  Yes [ ]  No Have you or any other household member(s) been ARRESTED or CONVICTED for any criminal activities in the past ten years (including drug-related offenses)? If yes, please state member(s) name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the charge or conviction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What county and/or state? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. [ ]  Yes [ ]  No Do you or any other household member(s) have to register as a sex offender? If yes, please state member(s) name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All information provided on this application and at the interview is subject to verification. All family members age 18 or older should review the information on this form, the Federal Privacy Act, and all required releases which MUST be signed in order to be considered for housing.**

**WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES AS TO ANY MATTER WITHIN ITS JURISDICTION.**

**By my signature below, I do swear and attest that all information on this application is true and correct. I understand that I must report any changes in income, assets, family composition, address, or phone number to the Housing Authority within 30 days of such change. By my signature, I grant permission for the Housing Authority to verify information necessary to determine my eligibility for housing. I further understand that false or incomplete statements are grounds for denial of this application.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Head of Household Date Signature of Spouse / Co-head Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Other Adult Date Signature of Other Adult Date

**EMERGENCY CONTACT INFO:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Filename: [INITIAL APPLICATION] CG 3/2013**