UPDATE APPLICATION Klamath Housing Authority

Please Use Ink

Name o	f Head of	f Housel	nold:							
Present	Address	:								
Mailing Address:						e-mail:				
Phone Number:				Work	#			Message #		
			Lis		ne liv	ing in 1	Househo			
First	Name Last	MI	Relation to Head	Date of Birth	Age	M or F	Student Y or N	Social Security #	Place Bir	
			Self							
			mily mem						Yes	
N N	Name: Name of a	ıbsent p	arent:							
Has any household member received HUD assistance previously?YesNo										
If yes, where and when?										
If yes, where and when?Has any member engaged in drug-related criminal activity? Yes No										
Has any	What? When?No What? When?No What? When?								No	
								\$\$\$\$\$\$\$\$		
	Please	e list all	checkir	ıg, savir	igs, C	D, Mon	ey Mark	et or other a	ccounts	
Nan	ne on Acco							count Number	Approxin Amour	
Singo	zour loc	t annai	ntmonte				<u> </u>			
Since your last appointment: Are you laid off? Yes No Date returning to work?										
On Maternity leave?YesNo Date returning to work Did you quit or get fired from a job?YesNo Date:										
EMPLOYMENT . Please list <u>all</u> income for <u>all</u> household members who receive wages – full time, part time and temporary, self-employment, paper routes, cash jobs, bartering, etc.										
								s, bartering, et <u>Gross Ear</u>		
								\$	_	

	ho	urs per		
		\$	per	
	ho	urs per		
List all other sources of hous Disability, Worker's Comp, \	sehold income: Welfare, SSI/S Unemployment, Alimony, Chilo ants, any lump sum settlements	SD/SSB, Social S l Support, Intere	Security, Pensi	
<u>Household Member</u>	<u>Source</u>		<u>Amount</u>	
		\$	per	
		\$	per	
		\$	per	
Does any family member ow Value:			YesN	No .
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	*****	*****
Do you pay for child care Cost per hour:\$	e? Total cost per week:\$	or mon	Yes th:\$	No
Does Welfare help pay? Your co-pay:\$			Yes	
Child Care Provider Name:_		Phone #		
Address:				
ELDERLY/DISABLED F. Do you have medicare?			Yes	No
Do you have any other kind	oremiums?of medical insurance? ne			No
Address	D	. ф		
Does the state pay any of you		. Ф	Yes	No
Do you make payments to a	doctor, hospital or pharmacy?		Yes	No
Name:Address:				
List any other doctor prescri	ibed/recommended out of pock	xet medical expe	nses:	

PRIVACY ACT STATEMENT: The information on this form is being collected by HUD to determine the applicant's eligibility, recommended unit size, and the amount of contribution by the family. It will be used to provide the basis for managing the programs covered by this form, for protecting the government's financial interest, and for verifying the accuracy of the information furnished. It may be released to appropriate Federal, State and local agencies when relevant, to civil, criminal or regulatory investigators of prosecutors. 42 USC 1437 et reg. OHCS 1981, PL 97-35, Stat 348.408.

I/We certify that the statements above are true and complete to the best of my/our knowledge. I/We

understand that false statements are pur	<u> </u>	37
Signature of Head of Household	Date	-
Signature of other adult	Date	-