



**PREBLE METROPOLITAN HOUSING AUTHORITY  
308 EATON LEWISBURG RD  
EATON OH 45320**



Phone: 937-456-2800

Fax: 937-456-3164

For Office Use Only

**Application for Waiting List  
Preble Metropolitan Housing Authority  
Section 8 Housing Choice Voucher Program**

Applicant Name: \_\_\_\_\_ Application Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

List the name, address, and phone number of two people who know how to contact you.

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Household Composition and Characteristics**

List the Head of Household and all other members who will be living in the unit.

No.	Full Name	Relation to Head	Birth Date	Age	Gender	Social Security #

1. Does anyone live with you now who is not listed in the household composition? \_\_\_Yes \_\_\_No

2. Does anyone plan to live with you in the future who is not listed? \_\_\_Yes \_\_\_No

Explain if you answered yes to either question: \_\_\_\_\_

3. If anyone listed is pregnant indicate member and due date: \_\_\_\_\_

4. Identify any special housing needs your household has: \_\_\_\_\_

5. Are you and all household members citizens of the United States? \_\_\_Yes \_\_\_No

6. How many people live in your unit now? \_\_\_\_\_ How many bedrooms do you have? \_\_\_\_\_

7. Do you wish to move? \_\_\_Yes \_\_\_No If yes, why? \_\_\_\_\_

8. Are you living in a federally subsidized housing unit? \_\_\_Yes \_\_\_No

9. Have you ever lived in public housing? \_\_\_Yes \_\_\_No

If yes, where? \_\_\_\_\_

10. Have you ever participated in the Section 8 Housing Choice Voucher Program? \_\_\_Yes \_\_\_No

11. Have you ever been evicted from public housing? \_\_\_Yes \_\_\_No

If yes, when? \_\_\_\_\_ For what reason? \_\_\_\_\_

Name of housing authority or owner: \_\_\_\_\_

12. Do you owe any money to a housing authority? \_\_\_Yes \_\_\_No

If yes, name of housing authority: \_\_\_\_\_

13. Have you ever been convicted of any activity related to illegal use of drugs? \_\_\_Yes \_\_\_No

14. Have you ever been convicted for any activity related to abuse of alcohol? \_\_\_Yes \_\_\_No

15. Have you ever been required to register as a sex offender? \_\_\_Yes \_\_\_No

16. Name and phone number of current landlord: \_\_\_\_\_

17. Your previous address: \_\_\_\_\_

Dates you lived there: \_\_\_\_\_

18. Name and address of previous landlord: \_\_\_\_\_

Phone number of previous landlord: \_\_\_\_\_



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Income and Asset Information

\*These questions are only for the purpose of calculating total tenant payment and determining the family's need for an accessible unit.

Please answer each of the following questions.

Form with columns for YES and NO, and a list of questions regarding household income, work status, and assets.

**Household Income**

Member Name	Source or Type of Income	Annual Income

**Household Assets**

List all checking and savings accounts (including IRAs, Certificates of Deposits, Direct Express accounts) for all household members.

Member Name	Bank Name	Type of Account	Balance

1. List the value of all stocks, bonds, trusts, pensions, or other assets owned by any household member.

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2. List the value of any assets disposed of for less than fair market value during the past two years:

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**Expenses**

Yes      No

       Do you have childcare expenses for children 12 years or younger?  
 If yes, name, address, and phone of care provider: \_\_\_\_\_  
 \_\_\_\_\_ Weekly cost: \_\_\_\_\_

       Do you pay for a care attendant or for any equipment for any disabled household member(s) which allows that person or another household member to work?  
 If yes, name, address, and phone of care provider: \_\_\_\_\_  
 \_\_\_\_\_ Weekly cost: \_\_\_\_\_



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**Elderly Families Only (62 years or older)**

Yes      No

\_\_\_\_\_      \_\_\_\_\_      Do you have Medicare?      If yes, monthly premium amount \$ \_\_\_\_\_

\_\_\_\_\_      \_\_\_\_\_      Do you have any other medical insurance?

\_\_\_\_\_      \_\_\_\_\_      Do you have outstanding medical bills? If yes, amount owed \$ \_\_\_\_\_

\_\_\_\_\_      \_\_\_\_\_      Do you expect to have medical expenses in the next twelve months?

**Applicant Certification**

I/We certify that the information given to the Preble Metropolitan Housing Authority 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 law. I/We also understand that false statements or information are grounds for denial of housing assistance and termination of tenancy.

I/We agree to keep PMHA informed of any change(s) in address. I understand that if PMHA attempts to contact me and I do not respond, my information will be withdrawn from the program and a new application will need to be completed.

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

Date \_\_\_\_\_

Signature of Spouse \_\_\_\_\_

Date \_\_\_\_\_

Signature of PMHA Staff \_\_\_\_\_

Date \_\_\_\_\_

*If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please contact the housing authority.*

*Housing discrimination complaints can be reported to the Fair Housing and Equal Opportunity National Hotline at 1-800-669-9777 or 1-800-877-8339 (hearing impaired).*



## U.S. Department of Housing and Urban Development Office of Public and Indian Housing

### DEBTS OWED TO PUBLIC HOUSING AGENCIES AND TERMINATIONS

**Paperwork Reduction Notice:** Public reporting burden for this collection of information is estimated to average 7 minutes per response. This includes the time for respondents to read the document and certify, and any recordkeeping burden. This information will be used in the processing of a tenancy. Response to this request for information is required to receive benefits. The agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. The OMB Number is 2577-0266, and expires 04/30/2023.

#### **NOTICE TO APPLICANTS AND PARTICIPANTS OF THE FOLLOWING HUD RENTAL ASSISTANCE PROGRAMS:**

- Public Housing (24 CFR 960)
- Section 8 Housing Choice Voucher, including the Disaster Housing Assistance Program (24 CFR 982)
- Section 8 Moderate Rehabilitation (24 CFR 882)
- Project-Based Voucher (24 CFR 983)

The U.S. Department of Housing and Urban Development maintains a national repository of debts owed to Public Housing Agencies (PHAs) or Section 8 landlords and adverse information of former participants who have voluntarily or involuntarily terminated participation in one of the above-listed HUD rental assistance programs. This information is maintained within HUD's Enterprise Income Verification (EIV) system, which is used by Public Housing Agencies (PHAs) and their management agents to verify employment and income information of program participants, as well as, to reduce administrative and rental assistance payment errors. The EIV system is designed to assist PHAs and HUD in ensuring that families are eligible to participate in HUD rental assistance programs and determining the correct amount of rental assistance a family is eligible for. All PHAs are required to use this system in accordance with HUD regulations at 24 CFR 5.233.

HUD requires PHAs, which administers the above-listed rental housing programs, to report certain information at the conclusion of your participation in a HUD rental assistance program. This notice provides you with information on what information the PHA is required to provide HUD, who will have access to this information, how this information is used and your rights. PHAs are required to provide this notice to all applicants and program participants and you are required to acknowledge receipt of this notice by signing page 2. Each adult household member must sign this form.

#### **What information about you and your tenancy does HUD collect from the PHA?**

The following information is collected about each member of your household (family composition): full name, date of birth, and Social Security Number.

The following adverse information is collected once your participation in the housing program has ended, whether you voluntarily or involuntarily move out of an assisted unit:

1. Amount of any balance you owe the PHA or Section 8 landlord (up to \$500,000) and explanation for balance owed (i.e. unpaid rent, retroactive rent (due to unreported income and/ or change in family composition) or other charges such as damages, utility charges, etc.); and
2. Whether or not you have entered into a repayment agreement for the amount that you owe the PHA; and
3. Whether or not you have defaulted on a repayment agreement; and
4. Whether or not the PHA has obtained a judgment against you; and
5. Whether or not you have filed for bankruptcy; and
6. The negative reason(s) for your end of participation or any negative status (i.e., abandoned unit, fraud, lease violations, criminal activity, etc.) as of the end of participation date.

**Who will have access to the information collected?**

This information will be available to HUD employees, PHA employees, and contractors of HUD and PHAs.

**How will this information be used?**

PHAs will have access to this information during the time of application for rental assistance and reexamination of family income and composition for existing participants. PHAs will be able to access this information to determine a family's suitability for initial or continued rental assistance, and avoid providing limited Federal housing assistance to families who have previously been unable to comply with HUD program requirements. If the reported information is accurate, a PHA may terminate your current rental assistance and deny your future request for HUD rental assistance, subject to PHA policy.

**How long is the debt owed and termination information maintained in EIV?**

Debt owed and termination information will be maintained in EIV for a period of up to ten (10) years from the end of participation date or such other period consistent with State Law.

**What are my rights?**

In accordance with the Federal Privacy Act of 1974, as amended (5 USC 552a) and HUD regulations pertaining to its implementation of the Federal Privacy Act of 1974 (24 CFR Part 16), you have the following rights:

1. To have access to your records maintained by HUD, subject to 24 CFR Part 16.
2. To have an administrative review of HUD's initial denial of your request to have access to your records maintained by HUD.
3. To have incorrect information in your record corrected upon written request.
4. To file an appeal request of an initial adverse determination on correction or amendment of record request within 30 calendar days after the issuance of the written denial.
5. To have your record disclosed to a third party upon receipt of your written and signed request.

**What do I do if I dispute the debt or termination information reported about me?**

If you disagree with the reported information, you should contact in writing the PHA who has reported this information about you. The PHA's name, address, and telephone numbers are listed on the Debts Owed and Termination Report. You have a right to request and obtain a copy of this report from the PHA. Inform the PHA why you dispute the information and provide any documentation that supports your dispute. HUD's record retention policies at 24 CFR Part 908 and 24 CFR Part 982 provide that the PHA may destroy your records three years from the date your participation in the program ends. To ensure the availability of your records, disputes of the original debt or termination information must be made within three years from the end of participation date; otherwise the debt and termination information will be presumed correct. Only the PHA who reported the adverse information about you can delete or correct your record. Your filing of bankruptcy will not result in the removal of debt owed or termination information from HUD's EIV system. However, if you have included this debt in your bankruptcy filing and/or this debt has been discharged by the bankruptcy court, your record will be updated to include the bankruptcy indicator, when you provide the PHA with documentation of your bankruptcy status.

The PHA will notify you in writing of its action regarding your dispute within 30 days of receiving your written dispute. If the PHA determines that the disputed information is incorrect, the PHA will update or delete the record. If the PHA determines that the disputed information is correct, the PHA will provide an explanation as to why the information is correct.

**This Notice was provided by the below-listed PHA:**

**I hereby acknowledge that the PHA provided me with the  
*Debts Owed to PHAs & Termination Notice:***

**Signature**

**Date**

**Printed Name**

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.



## Miami Valley Community Action Partnership CSBG Customer Intake Application

<b>Client Number:</b>	<b>Program Name:</b>			<b>Application Date:</b>
<input type="checkbox"/> Emergency Services <input type="checkbox"/> Getting Ahead <input type="checkbox"/> Legal Clinic <input type="checkbox"/> Transportation <input type="checkbox"/> Housing <input type="checkbox"/> Weatherization <input type="checkbox"/> Computer Learning <input type="checkbox"/> Home Repair <input type="checkbox"/> Micro Enterprise <input type="checkbox"/> IDA				
<b>Primary Applicant</b>				
<b>First Name:</b>	<b>M.I.:</b>	<b>Last Name:</b>		
<b>Social Security Number:</b>	<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		
<b>Disabled:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Veteran:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Food Stamps:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Residential Address:				
Current Mailing Address (if different from above):				
City:	State:	Zip Code:	County:	
Phone Number:		Email Address:		
<b>Race:</b>		<b>Education:</b>		<b>Ethnicity:</b>
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Other		<input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 (Non Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12 + Post-Secondary <input type="checkbox"/> 2-4 Yr. Grad College		<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins
<b>Household Information:</b>				
<b># In Household:</b>	<b>Family Type</b>	<b>Building Type</b>	<b>Work Status</b>	<b>Health Insurance Type</b>
	<input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Non-related Adults with children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other	<input type="checkbox"/> Mobile Home <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-family low- rise (3 stories or less) <input type="checkbox"/> Multi-family high-rise (3 stories or more)	<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults
<b>Housing Status</b>				
<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent <input type="checkbox"/> Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other				
<b>Source of Income:</b>			<b>Income Period:</b>	<b>Income Amount:</b>
<input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Self-Employment <input type="checkbox"/> No Income <input type="checkbox"/> Social Security <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Pension <input type="checkbox"/> Disability <input type="checkbox"/> Child Support <input type="checkbox"/> Other (Please Specify) _____			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
<b>Household Members:</b>				
Last Name:				
First Name:				
Social Security #				
Date of Birth:				
Gender:				
Race:				
Education:				
Ethnicity:				
Disabled Y/N:				
Health Insurance:				
Relationship (i.e. daughter, son, spouse etc.)				
Income source:				

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION FOR INFORMATION EXCHANGE

By signing this authorization, I grant permission for the sharing of information which is to be used to determine eligibility for participation in the Community Services Block Grant (CSBG) or other agency programs under the umbrella of Community Action as operated by the Miami Valley Community Action Partnership for either myself or my family members.

I understand this release will terminate one year from the date I sign this authorization or sooner if I request so in writing.

I understand that all information obtained in association with this release will be held in strict confidence by the recipient.

I further direct that information shared resulting from my signature not be further disclosed without my specific written authorization.

I further declare that I understand and permit an information exchange strictly for disclosure purposes related to Miami Valley Community Action Partnership programming.

I also hereby give permission to release to and /or secure information from the following organizations for the purpose of securing services I have requested:

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\_\_\_\_\_  
Customer Name (Printed)

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
MV Community Action Partnership Staff Signature

\_\_\_\_\_  
Date





## MVCAP Record of Income/Income Self-Declaration Form

Customer Name:		Email Address:	
Address:		Phone #	
City:	State:	Zip:	
Household Income Information			
Household member name	Source of Income	Last 30 Days amt.	
Self			
Income Category:		Frequency:	Total Amount:
<input type="checkbox"/> Fixed	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> SSA <input type="checkbox"/> Pension <input type="checkbox"/> Widow/Widower's benefit <input type="checkbox"/> Adoption Assistance <input type="checkbox"/> Alimony <input type="checkbox"/> Black Lung pension	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Earned	<input type="checkbox"/> Wages <input type="checkbox"/> Self-employment <input type="checkbox"/> Active Military Pay <input type="checkbox"/> Ohio Electronic Childcare	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Supplemental	<input type="checkbox"/> Unemployment <input type="checkbox"/> Utility Assistance <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Ohio Works First (TANF, ADC)	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<input type="checkbox"/> Other	<input type="checkbox"/> Cash withdraws from: IRA, Annuities, Other investments <input type="checkbox"/> Lump sum payout from: SSI, SSDI, Estate & Trust settlements, divorce settlements, insurance payout, lottery winnings <input type="checkbox"/> Interest Income	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<b>Total:</b>			\$ _____

~ Please turn over to complete/sign ~

<b>Deductions:</b>		
Deductible Income:	Frequency:	Total Amount:
<input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Health Care Spending Accounts <input type="checkbox"/> Medicaid Spend Down (deductibles) <input type="checkbox"/> Medicare Part D (RX premium) <input type="checkbox"/> Child Support paid-out <input type="checkbox"/> Attorney fees for estate or trust settlements	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____
<b>Total Household Income (Countable Income minus Deductions)</b>		\$ _____
<b>Excluded Income</b>		
Excluded Income:	Frequency:	Total Amount:
<input type="checkbox"/> Agent Orange Pension <input type="checkbox"/> Veterans affairs, service-related disability <input type="checkbox"/> Handicapped income (i.e. work programs for the blind or disabled) <input type="checkbox"/> Title V wages (i.e. senior employment programs) <input type="checkbox"/> Volunteers in Service to America Stipend (VISTA) <input type="checkbox"/> Work allowances (work requirement to receive OWF assistance) <input type="checkbox"/> Income earned by dependent minors <input type="checkbox"/> Tax refunds/rebates <input type="checkbox"/> Education assistance (grants stipends for tuition/books) <input type="checkbox"/> Stipends for foster care <input type="checkbox"/> Military allowances for subsistence <input type="checkbox"/> Ohio waiver program (Medicaid benefit for caregiver) <input type="checkbox"/> Prevention retention and contingency (i.e. emergency services, rental asst.) <input type="checkbox"/> Transportation allowances (WIOA) <input type="checkbox"/> Proceeds from reverse mortgage <input type="checkbox"/> FEMA, cash payments <input type="checkbox"/> Title III Disaster relief emergency assistance	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$ _____

***I understand that by signing this form, I authorize the Ohio Department of Development, Office of Community Services, or its designated representatives to access public assistance, social security, employment, or other records needed to verify these statements.***

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verified by: \_\_\_\_\_ Date: \_\_\_\_\_