

# Application for Continued Occupancy Form

Renewal Date: \_\_\_\_\_

1. **Name and relationship of ALL** persons living in your household, including date of birth and Social Security Number.  
(Our use of each person's Social Security Number is limited to income verification only.)

| Name | Relationship      | Date of Birth | Social Security Number |
|------|-------------------|---------------|------------------------|
|      | Head of Household |               |                        |
|      |                   |               |                        |
|      |                   |               |                        |
|      |                   |               |                        |
|      |                   |               |                        |
|      |                   |               |                        |

2. **Total Gross Income** for ALL household members and ALL sources. Persons over the age of 18 who live in the household must provide verification of income. Each person over the age of 18 who is unemployed must submit a Statement of No Income Form and a signed and dated Release Form.

| Income                                                    | Weekly | Monthly | Annually |
|-----------------------------------------------------------|--------|---------|----------|
| Gross Wages BEFORE deductions                             |        |         |          |
| Interest/Dividends (Form 1099)                            |        |         |          |
| Commissions, tips, bonuses, other income (Form 1099)      |        |         |          |
| Self-Employed net income (at least 15% of gross receipts) |        |         |          |
| Pension, Annuity, Retirement (gross amount)               |        |         |          |
| Alimony, child support, foster care (gross amount)        |        |         |          |
| Unemployment and Disability Compensation                  |        |         |          |
| Social Security Benefits (gross amount)                   |        |         |          |
| Public Assistance TAFDC (gross amount)                    |        |         |          |
| Other (please specify):                                   |        |         |          |
| Total Gross Income                                        |        |         |          |

Name of Employer \_\_\_\_\_ Address \_\_\_\_\_ Occupation \_\_\_\_\_

| 3. Allowable Deductions from Gross Income (subject to verification):                          | Annually |
|-----------------------------------------------------------------------------------------------|----------|
| \$400 for Head of Household if handicapped/disabled – <b>Family Units Only</b>                |          |
| \$300 for each minor member (under age 18) and each income contributing adult other than head |          |
| Non-reimbursable medical expenses over 3% of gross income (including medical insurance)       |          |
| Care of children/sick persons necessary for employment                                        |          |
| Support payments made (Child Support)                                                         |          |
| Tuition and fee (vocationally-related post-secondary education for member other than "FTS")   |          |
| Necessary handicapped homemaking or household expenses                                        |          |
| Total Deductions                                                                              |          |

Total Net Income

**Notes:**

**Income Verification:** Please submit verification of all income that you are receiving at this time. Interim re-determinations and changes in rent will NOT take effect until all information is received! All income must be verified as to what you are **CURRENTLY** receiving.

**Deduction Verification:** When submitting your medical deductions, it must be verified that you have **ALREADY** paid. You may submit cancelled checks. All deductions must be what you have paid during the previous 12-month period. If it is not verified that the deductions were paid, the AHA cannot use them for out-of-pocket expenses.

*The undersigned hereby certifies that the financial data supplied by this tenant is timely and accurate in all respects. The undersigned also understand that misrepresentation of these facts is grounds for termination. I hereby certify that all of my sources of income have been stated correctly in this Application for Continued Occupancy.*

***Signed under the pains and penalties of perjury:***



Signature – Head of Household



Date

Please print name clearly

Telephone

E-mail Address

**EMERGENCY CONTACTS:**

1. Name and Address

Relationship

Telephone

2. Name and Address

Relationship

Telephone

**Earned Income Exclusion**

This exclusion can only be used if you have been collecting from TAFDC, SSI, SS or DISABILITY. If you started working and, as a result of your new income, your benefits were decreased or terminated because of employment, you may have the option of having your rent frozen for the next 12 consecutive months, calculating your rent using the above income source. This exclusion may only be exercised once.

**Welfare to Work Exclusion (Please check off A, B or C below)**

- ☐ To be taken this year (please complete line "A" below)
- ☐ Deferred
- ☐ Not applicable

A. Member(s) name: \_\_\_\_\_

Income Source – previous 12 months: \_\_\_\_\_

Current Income Source: \_\_\_\_\_



## Authorization for Release of Information

(To be completed by all household members over the age of 18 years)

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

I, the above named individual, have authorized the Attleboro Housing Authority to verify the accuracy of the information, which I have provided to the Housing Authority, from the following sources:

- |                                                                 |                                                 |
|-----------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Criminal Offenders Records Information | <input type="checkbox"/> Financial Institutions |
| <input type="checkbox"/> Employer/D.E.T.                        | <input type="checkbox"/> Physician              |
| <input type="checkbox"/> Transitional Assistance                | <input type="checkbox"/> Landlord References    |
| <input type="checkbox"/> Social Security                        | <input type="checkbox"/> Other: _____           |

I hereby give you my permission to release this information to the Attleboro Housing Authority subject to the condition that it be kept confidential. I would appreciate your prompt attention in supplying the information requested on the attached page to the Attleboro Housing Authority within five (5) days of receipt of this request.

I understand that a photocopy of this Authorization is as valid as the original.

Thank you for your assistance and cooperation in this matter.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Fair Information Practices Act-Statement of Rights

The Attleboro Housing Authority collects information about applicants and tenants for its housing programs as required by law in order to determine eligibility, amount of rent and correct apartment size. The information collected is used to manage the housing programs, to protect the public's financial interest and to verify the accuracy of information submitted. When permitted by law, it may be released to government agencies, other housing authorities and to civil or criminal investigators and prosecutors. Otherwise, the information will be kept confidential and only used by Housing Authority staff in the course of their duties.

The Fair Information Practices Act established requirements governing housing authorities' use and disclosure of the information it collects. Applicants and tenants may give or withhold their permission when requested by the Housing Authority to provide information: however, failure to permit the Housing Authority to obtain the required information may result in delay, ineligibility for programs or termination of tenancy or housing subsidy. The provision of false or incomplete information is a criminal offense punishable by fines and/or imprisonment. As an applicant or tenant, you have following rights in regard to the information collected about you. No information may be used for any purpose other than those described above without your consent.

1. No information may be disclosed to any person other than those described above without your consent. If we receive legal order to release the information, we will notify you.
2. You or your authorized representative has a right to inspect and copy any information. However, the Housing Authority reserves the right for a 24-hour notice in such cases in order to have someone available to assist you.
3. You may ask questions and receive answers from the Housing Authority about how we collect and use information.
4. You may object to the collection, maintenance, dissemination, use, accuracy, completeness or type of information we hold about you. If you object, we will investigate your objection and will either correct the problem or make your objection part of your file. If you are dissatisfied, you may appeal to The Department of Housing and Community Development.

I have read and understand this Fair Information Practices Statement of Rights.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





## Statement of No Income Form

### TO BE FILLED OUT ONLY IF YOU DO NOT HAVE AN INCOME

Date: \_\_\_\_\_

I, \_\_\_\_\_ have not received any income  
(Printed Name)

since \_\_\_\_\_.

Please list how you pay the following (example: "my mother pays")

Rent: \_\_\_\_\_

Food: \_\_\_\_\_

Car Insurance: \_\_\_\_\_

Utilities: \_\_\_\_\_

Signed under pains and penalties of perjury:

\_\_\_\_\_  
(Signature)

State of Massachusetts  
County of Bristol

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me the undersigned notary public,  
personally appeared \_\_\_\_\_, proved to me through satisfactory  
evidence of identification, which were, \_\_\_\_\_, to be the person whose  
name is signed on the preceding or attached document, and who acknowledged to me that (he)  
(she) signed it voluntarily for its stated purpose.

\_\_\_\_\_  
(official signature and seal of notary)

My commission expires \_\_\_\_\_