App. # __________

Section 8 Programs
- ☐ Existing Certificates
- ☐ Vouchers
- ☐ Mod. Rehab.
- ☐ Family Self Sufficiency

App. # __________

Traditional Public Housing
- ☐ Family
- ☐ Senior

14 Baxter Boulevard, Portland, ME 04101
(207) 773-4753
APPLICATION FOR RE-CERTIFICATION

Federal regulations require regular re-examinations of income and composition of all families at least once every twelve (12) months. Interim re-examinations will be conducted if there is a change of income and/or family composition. Such a change must be reported immediately in compliance with the PHA Dwelling Lease, statement/ certificate of family participation and family responsibilities. Failure to complete this form on or before __________ with all required verifications could result in termination of lease and/or termination of housing assistance.

PLEASE PRINT
Fill in ALL Blanks or Write "None"

GENERAL INFORMATION

Name: ____________________ Telephone: ____________________

Address: ____
Street Apt.# City,State,Zip

Mailing Address: ____
Street Apt. # City,State,Zip

FAMILY HOUSEHOLD COMPOSITION

List ALL household members who WILL LIVE in the apartment.
List YOURSELF first, spouse (significant other) second, children third (oldest first), then additional adults.

Name	Relationship	Birth Date	Place of Birth City/State/County	Social Security #	Occupation or Name of School
1.	SELF				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Race of Head of Household
- ☐ Caucasian/Other
- ☐ African/African American
- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Island Native

Ethnicity of Head of Household
- ☐ Hispanic
- ☐ Non-Hispanic

Do You require a translator?
- ☐ Yes, What Language________
- ☐ No

Do you, or any member of your household have any special housing needs or require any reasonable accommodation? ☐No ☐ Yes: ____

____

Are you attending school or taking any educational courses? ☐ No ☐Yes
If yes, what is the name of the school?____________________

INCOME

List income for each family member, including children, high school & college students. Income must be listed even if it is not counted for rent. ***For each Source of Income, please list each family member who is receiving benefits.***

SOURCE OF INCOME	FAMILY MEMBER NAME*	MONTHLY AMOUNT	FAMILY MEMBER NAME*	MONTHLY AMOUNT
Social Security/SSDI	1)	$	4)	$
	2)	$	5)	$
	3)	$	6)	$
SSI	1)	$	4)	$
	2)	$	5)	$
	3)	$	6)	$
Pension	1)	$	2)	$
TANF	1)	$	2)	$
Child Support (through DHS)	1)	$	2)	$
Child Support (through father)	1)	$	2)	$
	Name: ____ Address: ____		Name: ____ Address: ____	
Wages (***enclose 3 pay stubs***)	1)	$	3)	$
	Employer: ____ How long: ____		Employer: ____ How long: ____	
	2)	$	4)	$
	Employer: ____ How long: ____		Employer: ____ How long: ____	

SOURCE OF INCOME	FAMILY MEMBER NAME*	MONTHLY AMOUNT
Veteran's Benefits		$
Alimony Name: ____ Address: ____		$
General Assistance (city)		$
Unemployment Compensation		$
Worker's Compensation Co. Name: ____ Address: ____		$
Self-employment (***enclose last year's tax return***) How long: ____		$
Assistance from others outside this household, cash & non-cash (e.g. groceries, utility bills paid, etc.) Name: ____ Address: ____		$
Dividends Investment:		$
Financial Aid for college students (***attach most recent award letter***):		$
Other		$
THESE MUST BE LISTED BUT WILL NOT BE COUNTED IN RENT:		
Food stamps		$
Foster Grandparents		$
Heating Assistance		$
Earned Income Tax Credit Refund		$
RSVP		$
VISTA or AMERICORP		$
Stipends from any other volunteer program		$
Maine The Pine Tree Card EBT NO:		$

ASSETS

List assets for each family member.

ASSETS	NAME ON ACCT	ACCOUNT # OR POLICY #	AMOUNT
Bank Account Name of Bank/Credit Union: ______ Type of account: ______			$
Bank Account Name of Bank/Credit Union: ______ Type of account: ______			$
Bank Account Name of Bank/Credit Union: ______ Type of account: ______			$
Life Insurance Policy Name of Company: ______ Address: ______			$
Life Insurance Policy Company: ______			$
Life Insurance Policy Company: ______			$
Investment Accounts *(stocks, IRA's, money markets, etc.)* Name of Company: ______ Address: ______ Type of investment: ______			$
Investment Accounts *(stocks, IRA's, money markets, etc.)* Name of Company: ______ Address: ______ Type of investment: ______			$
Bonds *(enclose copies)* Type: ______			$
Other			$
Other			$

Do you own any real property? ☐ No ☐ Yes If yes,
Address of property: ______
Is there a mortgage? ☐ No ☐ Yes If yes,
Name and address of mortgage company: ______

Have you sold any real property in the past 3 years? ☐ No ☐ Yes If yes,
Address of property: ______
Please provide copy of bill of sale

Do you own any personal property that you keep as an investment, such as coin collection, jewelry, antique cars, etc.? ☐ No ☐ Yes If yes,
Description: ______
Value: ______

ALLOWANCES

Do you pay for child/adult care to allow head or spouse to be employed or attend school? ☐ No ☐ Yes
Name/address of care provider: ______

Do you need to pay for special care or equipment for a disabled member of the family to enable any family member to work? ☐ No ☐ Yes If so, describe: ______

ALLOWANCES CONTINUED

If head or spouse is disabled or 62 years of age or older, please answer the remaining questions:

- Are you receiving Medicare? ☐ No ☐ Yes $__________ per month
- Are you enrolled in a Medicare-approved prescription drug plan *(the Medicare prescription drug program seal will be on the front of the card, which includes the words "Medicare Rx")*? ☐ No ☐ Yes

  If yes, please provide the name of your plan: ____________________________

  How much is your monthly payment? $__________ per month

  Please bring documentation of your participation with you to your interview.

- Do you have any other medical insurance? ☐ No ☐ Yes

  Name of Company: ____________________

  Address ____________________

  Policy #: ____________________

  If you have Anthem/Blue Cross or AARP health insurance, please provide verification of payment

- Out-of-pocket medication expenses (not covered by insurance): $________ per month

  Name/address of pharmacy:

  ____

  ____

- Out of pocket physician/medical expenses (not covered by insurance): $________ per month

  Name/address of medical providers:

  ____

  ____

  Do you have a recurring monthly medical payment not covered by insurance? ☐ Yes ☐ No

  If yes, to whom and how much? ____________________________

EMERGENCY INFORMATION: Please list two persons who are not members of your household that we may contact in case of an emergency:

Name	Address	Phone	Relationship
Name	Address	Phone	Relationship

CERTIFICATION

I/we certify that the statements in this Application for Re-Certification are true and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal Law.

Signature	Date	Signature	Date