

BRISTOL HOUSING AUTHORITY

Annual Recertification Questionnaire

Warning: False statements are grounds to terminate housing assistance and are prosecutable under Federal & State law.

Instructions: PLEASE PRINT All sections of this form must be completed in your own handwriting using black or blue ink. Use the correct legal name only. Provide additional information for verification. All changes in family composition and income after this declaration must be reported in writing within 10 days. All members of household must also sign this form. Incomplete answers and information will cause delay.

Name of Head of Household

Telephone #

Apt #

Cell Phone #

Email Address

FAMILY COMPOSITION: List all person LIVING WITH YOU, including yourself

Family Member's Full Name	Relationship to Head	DOB	SS #	Sex
	Head			

Have there been any changes in the family composition of the household? (Has anyone joined or left household?)

Yes No If yes, please explain _____

Is any family member temporarily absent from the apartment? Yes No

Please Explain: _____

CURRENT EMPLOYER (Are You Employed, If NOT, Write "None")

Name	
Address	
City/ County/ Zip	
Date of Hire	
Work Phone	
Position	
Annual Income	\$
Supervisor	
Fax Number	



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FAMILY INCOME INFORMATION: List ALL income earned or received by everyone living in your household.

INCOME: PLEASE ANSWER EACH QUESTION BELOW

FREQUENCY AMOUNT

1. Wages, Salary (includes Overtime, tips, bonuses & self-employment?)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
2. Does any member work for someone who pays them cash?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
3. Do you have an Annuity? From: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
4. Do you have Rental Income from Property You Own?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
5. Do you receive a Pension? From: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
6. Social Security Benefits and/or SSI Payments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
7. Social Security Supplemental, (SSP)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
8. Welfare Benefits (General Aid)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
9. Do you received regular cash contributions or gifts from individuals not living in the unit or organizations (includes rent, utilities, groceries, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
10. Unemployment Benefits/Severance Pay?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
11. Workers Compensation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
12. Do you have a Court Order for Alimony?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
13. Do you receive Alimony?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
14. Regular Pay as Member of Armed Forces or VA Benefits (circle one)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
15. Death Benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
16. Disability Benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$
17. Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>		\$

ASSETS: PLEASE ANSWER EACH QUESTION

1. Do you have a Checking Account? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, PROVIDE THE MOST CURRENT CHECKING ACCOUNT STATEMENTS FOR EACH ACCOUNT		
2. Do you have a Savings Account? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, PROVIDE THE MOST RECENT CURRENT SAVINGS ACCOUNT STATEMENT		
3. Do you or any household members own, have an interest in any real estate, boat, and/or mobile home? (circle which applies to you)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Do you have any Money Market Accounts? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Do you have any Certificate of Deposit Accounts? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you or any household member(s) received any lump sums of money in the last year. Ex., lottery, inheritance, Social Security lump sum, etc.?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Do you or any household member own Stocks or Bonds? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Do you have a 401K, 403B, Keogh Account, IRA Account? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Do you have Whole Life Insurance? Name of Company _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Do you have an Annuity? What is the current balance? _____ Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Other Assets Not Listed Above? Where? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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DISPOSAL OF ASSETS

Have you disposed of assets for less than fair market value in the two years (24 months) proceeding the date of this certification? Any asset that is disposed of for less than its full value is counted, including cash gifts as well as property. Assets that are disposed of include, but are not limited to, assets that are given away or sold for less than the fair market value. _____ YES OR _____ NO

If an asset was disposed of, please complete the following information.

List the asset(s) that was disposed:

List the Date that the asset was disposed: _____

What was the fair market value of the asset? \$ _____

The amount received for the asset was: \$ _____

Disability and Care Attendant Expenses

Do you pay for a care attendant or any equipment for a disabled household member necessary to enable that person or someone else in the household to work? If yes, enter the provider's name and address.

Yes

No

What is your Out-of-Pocket Cost: \$ _____

Provider Name:

Address:

Phone #:

Medical Expenses ~ Provide Paid Receipts from Medical Provider or Cancelled Checks

Type	Yes	No	Cost	Frequency
1. Do you pay for dental expenses? Where: _____				
2. Do you pay for a dental premium? Where: _____				
3. Do you pay for Medicare Part B?				
4. Do you pay for Medicare Prescription (Part D)?				
5. Do you pay for Other Healthcare Premiums (Blue Cross, United Health, etc.) Specify: _____				
6. Do you pay for Prescriptions? Please bring Payment History Printout				
7. Do you pay for Other Medical Expenses? Where:				
8. Do you pay for Other Medical Expenses? Where:				
9. Do you pay for Other Medical Expenses? Where:				



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MISCELLANEOUS INFORMATION

1. Are you or any member of your household subject to a **State Lifetime Sex Offender Registration Program** in any state?
 Yes No If yes, which state(s)? _____
2. Please list all states in which you or any other household members have resided:

3. Within the past 3 years, have you or any adult household member been charged and convicted of possession of narcotics or a violent crime? Yes No

I certify that the information I have provided on this Annual Recertification Questionnaire is complete, correct and true. I also understand that I **MUST** report all changes of income or family composition within ten (10) business days.

I acknowledge that if I do not report changes of family income or family composition, I will be subject to termination from the Bristol Housing Authority or be responsible to repay debts owed to the Bristol Housing Authority.

Signature of Head of Household

Date

Other Adult Household Member

Date

Public Housing Manager

Date

