



Delano Economic Development Authority
“Serving Delano’s Housing Needs”

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Crow River Villa
125-5th St South
Delano, MN 55328

Application for Housing Assistance And Recertification of Eligibility

You are requesting a housing assistance payment through the Rental Assistance Program. Complete this form so that a decision can be made regarding your eligibility for a housing assistance payment.

Please complete each question of the form and sign the form on the back page.

**I. APPLICANT
 NAME** _____

ADDRESS _____

Street, Box No.

City

County

State

Zip

TELEPHONE _____

Home

Work

If no telephone: How can we reach you: _____

II. HOUSEHOLD COMPOSITION: List each family member who will live in your household Including yourself. Clearly identify full- and part-time students over 18 years of age under relationship. (see bottom of page)

Name	Relationship to Household Head*	Sex (M or F)	Date of Birth (MM DD YYYY)	Soc. Sec. No.	Disability (Y/N)	Soc. Sec. or VA Claim No. **
1	Head					
2						
3						
4						
5						

NOTE: A full-time student who lives out of town, but returns home for at least three consecutive months per year, is allowed bedroom assignment. A part-time student living away from home is not allowed bedroom assignment.

* S=Spouse, F=Foster Child, Y=Youth Under 18, E=Full Time Student, L=Live-in-Aide, A=other Adult

** See your Medicare and/or Medicaid Cards(s)

III. HEAD OF HOUSEHOLD CODE (Check one)

- 1. White _____
- 2. Black _____
- 3. Native American or Alaskan _____
- 4. Asian or Pacific Islander _____

Ethnicity (Check one)

- 1. Hispanic _____
- 2. Non-Hispanic _____

IV. OTHER CONTACT PERSON

If you need another person notified of changes in your rent, leases or other information please enter the information below:

Name _____
 Address _____
 City, State, Zip _____
 Phone _____

If you are receiving Public Assistance, (AFDC, GENERAL ASSISTANCES, etc.) provide your case #, Supervisor, and their phone #.

Welfare # _____ Supervisor _____ Phone # _____

V. Assets. List assets for all household members. Each item must be checked "Yes" or No."

Name and address of bank, credit union, or savings and Loan (Branch) which can verify this item.

Account No.

Checking Account:

Yes _____ No _____ Amount \$ _____

Savings C.D.'s:

Yes _____ No _____ Amount \$ _____

Bonds (any type):

Yes _____ No _____ Amount \$ _____

(List Series, Face Amount, and month and year purchased on separate sheet).

Money Market Funds

Yes _____ No _____ Amount \$ _____

Stocks:

Yes _____ No _____ Amount \$ _____

Equity in Real Property

Yes _____ No _____ Amount \$ _____

(Send county Treasurer's Tax statement. If you are making payments, please attach an amortization statement.)

Other: (Type) _____

Yes _____ No _____ Amount \$ _____

Have you disposed of any assets in the past two years?* Yes _____ No _____

If yes: what was disposed of? _____ Value of Assets \$ _____

* If you have sold property Contract-for Deed, attach a copy of the contract and an amortization statement.

VI. INCOME

Declare the income for the head of the household, spouse and all household members age 18 and over who are currently receiving income or expect to receive income in the next 12 months. This includes family members who are temporarily absent, such as members serving in the Armed Forces, or members temporarily employed away from home. Benefits received on behalf of minors are also considered income.

EXAMPLES OF INCOME

YES	NO	
_____	_____	(U) Unemployment or Workmen's Compensation/Severance Pay
_____	_____	(SS) Social Security
_____	_____	(SI) Supplemental Security Income
_____	_____	(PE) Retirement of Pension Income (Annuities/Insurance Policies)
_____	_____	(D) Public Assistance (AFDC)
_____	_____	(G) General Assistance
_____	_____	(W) Earned Income or Wages/Self Employment/Odd Jobs
_____	_____	(F) Federal Wages
_____	_____	(N) Contributions of Gifts
_____	_____	(B) Net Income from a Business
_____	_____	(N) Alimony
_____	_____	(CS) Child Support/Child Support Pass Through
_____	_____	(M) Military Pay (V.A. Benefits) Enter VA Claim Number# _____
_____	_____	(AI) Income from Assets (Such as Savings, CD's Stocks, Etc.)
_____	_____	(N) Lottery Winnings
_____	_____	(SI) State Supplement for Supplemental Security Income
_____	_____	(I) Leased Land Trust Income

Other (Please list any other income you or any members of your family receive.)

If you have checked yes to any of the above, please complete below:

Name of Family Member			
Name of Employer or Source of Income			
Address			
City, State, Zip			
Gross Income (Before Deductions)			
How Often Received M-Monthly B-Biweekly W-Weekly O-Other (explain)			

VII. FOR MEMBERS LISTED IN PART II AS DISABLED OR HANDICAPPED, LIST THE EXTENT OF THE DISABILITY OR HANDICAP.

Name of Family Member	Type of Disability or Handicap
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1. _____
2. _____

Do you have any unusual expenses related to employment, such as a care attendant or auxiliary apparatus for a handicapped or disabled family member? Yes _____ No _____

If Yes, Please explain _____

* If you are a new applicant and the head of the household or the spouse is disabled or handicapped, your doctor will be contacted for proper verification.

Name of doctor	Address
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Head of Household or spouse disabled? Yes _____ No _____
 Head of Household or spouse 62 or older? Yes _____ No _____
 If no to both of these, omit section VIII

VIII. MEDICAL EXPENSES (Medical expenses for elderly, disabled, or handicapped only.) Indicate on whose behalf medical expenses will be incurred for the next 12 months. Please attach a statement from the vendor (i.e. doctor, clinic, pharmacy, etc.) indicating the outstanding balance and the amount of monthly payment.

Name of Family Member	List name of doctor, hospital clinic, and/or drug store	Address	Medical Costs	
			Monthly	Annually

1. _____
2. _____
3. _____
4. _____

Name of Health Insurance Company _____

Premium \$ _____ Mo. _____ Qtrly. _____ Annually _____

Please attach a statement from the company indicating the annual premium and the frequency of payment. Please attach receipts.

IX. CHILD CARE

Do you have child care costs related to working or going to school? Yes _____ No _____

Name of provider Address Phone # Cost

X. FULL TIME STUDENT

Provide the following information for each household member show is 18 and a full time student. Attach additional sheets if necessary.

_____ Name of Household Member Name & Address of Education Institute _____

1. _____

2. _____

XI. LIVING ARRANGEMENT In what type of dwelling do you live? (Check one)

Rented home	_____	In home of relative	_____
Rented mobile home	_____	Rented apartment	_____
Own Home	_____	Public Housing	_____
Own mobile home	_____	Other Assisted living	_____
Lot Rent	_____	Other	_____

XII. PRIOR EVICTIONS

Have you or any member in your household been evicted from public assisted housing in the past 3 years? _____ Yes _____ No

If yes, state reason and/or cause for eviction. _____

If yes, name and address of property evicted from: _____

XIII. If you are divorced or legally separated and have not furnished us with documentation before, please attach Copies of divorce decree of legal separation agreement.

APPLICATION/TENANT CERTIFICATION

Applicant(s)/Tenant(s) Statement

I/We certify that the information given on household composition, income, net family assets, and allowances and deductions is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements of information are grounds for termination of housing assistance and termination of tenancy.

I hereby certify that I will report all changes of income, family composition, or assets within ten (10) days of the date of the change. My signature below constitutes my consent for the agency to obtain verifying information from any necessary source.

Signature of Mark of Head of Household

Signature of Mark of Spouse (living with you)

DATE

Signature of Mark of all Household
Members ages 18 or older.

Signature of Person, if any, who
Helped you complete this form.

ADDRESS

PHONE NUMBER

RELATIONSHIP TO APPLICANT

If applicant signed with a mark "X", there must be two witnesses.

Witness No 1

Date

Witness No 2

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-free Hot Line at 800-424-8590.

* After certification by this Housing Agency, the information will be submitted to the Department of Housing and Urban Development on Form HUD-50058 (Family Report) or on magnetic media. See the Federal Privacy act Statement for more information about its use.