PERSONAL DECLARATION FORM

BRING COMPLETED FORM TO YOUR RECERTIFICATION APPOINTMENT

If you or anyone in your family is a person with disabilities that requires a specific accommodation in order to complete this form and/or to fully utilize our programs and services, please contact the housing authority for assistance (see contact information below).

FOR OFFICE USE ONLY: ☐ **Initial** ☐ **Annual** ☐ **Mover**

IT IS YOUR OBLIGATION TO NOTIFY US WITHIN TEN (10) DAYS IF ANY OF THE FOLLOWING INFORMATION CHANGES.

Please complete this form in ink. Complete all blanks. Write the word "NONE" if the information does not apply.
DO NOT SIGN UNTIL YOUR RECERTIFICATION APPOINTMENT, IN THE PRESENCE OF YOUR HOUSING SPECIALIST, OR YOU MUST SIGN IN THE PRESENCE OF A NOTARY.

PART I. TENANT INFORMATION

Are you renewing your lease? _____ Are you transferring/moving to another unit? _____

NAME: _____ **HOME PHONE:** _____
(Last) **(First)** **(Middle Initial)**

CURRENT ADDRESS: _____ **WORK PHONE:** _____

CITY, STATE, ZIP: _____ **CELL PHONE:** _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____

MAIDEN NAME, NICKNAME OR ALIAS (if applicable): _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER _____
If separated or divorced, list the name and address of the spouse/ex-spouse(s):

_____ (circle) SEPARATED DIVORCED
NAME ADDRESS SOCIAL SECURITY #

_____ (circle) SEPARATED DIVORCED
NAME ADDRESS SOCIAL SECURITY #

The following information is being requested to comply with Equal Opportunity requirements and will not affect your housing:
PRIMARY LANGUAGE: _____ TRANSLATION NEEDED? ☐ YES ☐ NO
RACE: ☐ CAUCASIAN ☐ AFRICAN AMERICAN ☐ NATIVE AMERICAN ☐ASIAN ☐ PACIFIC ISLANDER ☐ HISPANIC

EMERGENCY CONTACTS: Please list two individuals we may contact if you are not available:

Name: _____ Telephone: _____ Relationship: _____
Name: _____ Telephone: _____ Relationship: _____

PART II. HOUSEHOLD INFORMATION

Are you, or is anyone in your household, a Veteran? (circle) **YES NO** Was the Veteran Honorably or Medically discharged? (circle) **YES NO**

Please list YOURSELF and ALL PERSONS living in the assisted unit, INCLUDING ANYONE WHO SPENDS THE NIGHT MORE THAN FIFTEEN (15) NIGHTS PER YEAR.

MBR #	Last Name	First Name	MI	Age	Sex	Relation to Head	DOB	Marital Status	Disability? (Yes/No)	Social Security #
1					☐ Male ☐ Female	Head			☐ Yes ☐ No	
2					☐ Male ☐ Female				☐ Yes ☐ No	
3					☐ Male ☐ Female				☐ Yes ☐ No	
4					☐ Male ☐ Female				☐ Yes ☐ No	
5					☐ Male ☐ Female				☐ Yes ☐ No	
6					☐ Male ☐ Female				☐ Yes ☐ No	
7					☐ Male ☐ Female				☐ Yes ☐ No	
8					☐ Male ☐ Female				☐ Yes ☐ No	
9					☐ Male ☐ Female				☐ Yes ☐ No	
10					☐ Male ☐ Female				☐ Yes ☐ No	

Live-in Aides must be listed in the Household Composition but will not be considered a remaining member of the household and have no rights to the Voucher.

List all persons who moved out during the past 12 months (including any deaths, marriages, jail, permanent placement in nursing homes, etc.)

Full Name	Relationship	Date of Move	Reason

Please circle "YES" or "NO" to the following questions.

Do you expect anyone to move in or out of your household within the next twelve months? **YES** **NO**
If yes, explain: _____

Is there any member of the household who is now temporarily or permanently absent from the home? **YES** **NO**
If yes, explain: _____

Has any member of the household had a change in citizenship or immigration status? **YES** **NO**
If yes, explain: _____

Have you or any household member ever used a name other than the one you are using now? **YES** **NO**
If yes, please let us know who, what the name was, and why:_____

Do you have any overnight guests that spend 2 or more nights a month? **YES** **NO**
If yes, please list the guests' names and why:_____

Is the Head of Household or Spouse disabled? **YES** **NO**

Is any other family member disabled? (list names): _____ **YES** **NO**

Is a reasonable accommodation based on disability necessary? If so, please indicate below: **YES** **NO**

☐ Live-in Aid ☐ Additional Bedroom ☐ Rent Exception ☐ Hearing impaired Smoke Detector ☐ Other

Do you read, write and understand the English language? **YES** **NO**
If no, please explain: _____

Has any member of your household, including adults and minors, ever used a social security number other than the one lawfully assigned?
YES **NO**
If yes, please explain: _____

Are you now living, or have you **ever** lived in Public Housing, received Section 8 assistance or any other form of government assistance (as Head of Household or any other member of the family): **YES** **NO**

Are you currently, or have you ever been in a repayment status with any public assistance or assisted housing agency? **YES** **NO**

Have you ever been evicted from a **Public Housing or a HUD rental subsidized unit**?
YES **NO**
If yes, please list who evicted you and the dates. _____

Please list every city and state in which you have lived for the past seven years: _____

_____

I/we understand that an additional family member may not be added to the lease until I have submitted a request and the request has been formally approved by St. Petersburg Housing Authority (SPHA) and the Landlord. I/we certify that this Family Composition information given to SPHA is TRUE, ACCURATE, and COMPLETE. I know I am required to report, in writing, any changes in household size within ten (10) days. I understand the rules and regulations regarding guests/visitors and when I must report anyone who is staying with me. THIS MUST BE SIGNED IN THE PRESENCE OF AN SPHA REPRESENTATIVE OR A NOTARY.

_____	_____	_____
SIGNATURE, HEAD OF HOUSEHOLD	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE

I certify that I have reviewed the information on Family Composition for completeness and accuracy and am acting in accordance with Section 8 procedure.

_____	_____	_____
SIGNATURE, SPHA REPRESENTATIVE	PRINT NAME	DATE

PART III. CRIMINAL HISTORY

Please note that it is important that you answer these questions fully, accurately and honestly. Criminal history does not necessarily keep you from obtaining housing assistance. Attach additional paper if needed to explain your situation.

Please circle "YES" or "NO" to the following questions.

Has **any member of your household**, including adults and minors, **ever** engaged in, been cited, arrested, indicted, convicted, or placed on probation for, **or** had an adjudication withheld, or had charges dropped or nolle prossed in connection with drug related or violent criminal activity? (circle)
YES **NO**

If yes, who? _____
When? _____What was the outcome? _____
_____
In what city and state? _____

Has **any member of your household**, including adults and minors, **ever** engaged in, been cited, arrested, indicted, convicted, or placed on probation for, **or** had an adjudication withheld, or had charges dropped or nolle prossed in connection with any felony charge? (circle) **YES** **NO**

If yes, who? _____

What dates? _____

What was the outcome? _____

_____

In what city and state? _____

Has **any member of your household**, including adults and minors, **ever** engaged in, been cited, arrested, indicted, convicted, or placed on probation for, **or** had an adjudication withheld, or had charges dropped or nolle prossed in connection with committing fraud in a federally assisted housing program **or** has any household member been requested to repay money for knowingly misrepresenting information for such housing programs? (circle) **YES** **NO**

If yes, who? _____

What dates? _____

What was the outcome? _____

_____

In what city and state? _____

Has any household member used drugs or alcohol in the last **five (5) years** to the degree that it caused a problem? (circle)**YES** **NO**

If yes, who? _____

When? _____

Is any member of your household required to register as a sex offender? (circle) **YES** **NO**

If yes, who? _____

In what city and state did the offense occur? _____

On what dates? _____

Has **any member of your household**, including adults and minors, **ever** engaged in, been cited, arrested, indicted, convicted, or placed on probation for, **or** had an adjudication withheld, or had charges dropped or nolle prossed in connection with manufacturing or producing methamphetamine? (circle) **YES** **NO**

If yes, who? _____

In what city and state did the offense occur? _____

On what dates? _____

Has **any member of your household**, including adults and minors, **ever** been on parole or probation? (circle) **YES** **NO**

If yes, who? _____

When? _____

Is any family member still on parole or probation? (circle) **YES** **NO**

Who? _____

Who is/was the probation or parole officer and what is their contact number? _____

In what state did the offense occur? _____

What charges resulted in the parole or probation? _____

Has **any member of your household**, including adults and minors, **ever** been involved in drug court? (circle) **YES** **NO**

Who? _____

What incidents lead to their involvement with drug court? _____

On what dates did the incidents occur? _____

Is any household member, including adults and minors, currently involved with Department of Children and Families, mental health court, court coordinated services? (circle) **YES** **NO**

Who? _____

What incidents lead to their involvement with mental health court, court coordinated services, or DCF? _____

_____

On what dates did the incidents occur? _____

I/we certify that this Criminal Background information given to the St. Petersburg Housing Authority is TRUE and ACCURATE. I understand that knowingly supplying false, incomplete, or inaccurate information is punishable under Federal or State criminal law. I understand that knowingly supplying false, incomplete, or inaccurate information is grounds for termination of housing assistance or termination of tenancy. <u>THIS MUST BE SIGNED IN THE PRESENCE OF AN SPHA REPRESENTATIVE OR A NOTARY.</u>

_____	_____	_____
SIGNATURE, HEAD OF HOUSEHOLD	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE

I certify that I have reviewed the information on Criminal History for completeness and accuracy and am acting in accordance with Section 8 procedure.

_____	_____	_____
SIGNATURE, SPHA REPRESENTATIVE	PRINT NAME	DATE

PART IV. FAMILY DEDUCTIONS

Please circle "YES" or "NO" to the following questions.
CHILDCARE
Do YOU pay child care for a family member under the age of thirteen (13)? **YES** **NO**
For which child(ren)? ______________________________

Child Care Name: ______________________________
Address: ______________________________
Total Monthly Cost: ______________ Your cost: ______________
Do you receive financial assistance with your child care costs from the State? **YES** **NO**
If yes, how much? ______________________________

HANDICAPPED ASSISTANCE EXPENSES
Do you employ a Care Attendant or supply Auxiliary Apparatus (i.e., a wheelchair) for a disabled family member in order to allow a family member, age 18 or older, including the disabled member, to become gainfully employed? **YES** **NO**

MEDICAL EXPENSES
If the head of household or spouse is 62 years of age or older, or a person with diabilities, you may complete this sheet to have your household medical expenses considered in the determination of your housing benefits. All members of the household age 18 and over who have medical expenses should sign this form if their medical expenses are to be considered.

HIPAA COMPLIANT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
By signing this form, I authorize **the health care providers listed below** to disclose any information requested concerning the cost of my medical treatment to the St. Petersburg Housing Authority (SPHA). The SPHA may use this information only for the purpose of verifying my eligibility for and/or the amount of my housing assistance.

I understand that I have the right to revoke this authorization at any time by notifying SPHA in writing at 2001 Gandy Blvd. North, St. Petersburg, FL 33702. I understand that the revocation is only effective after it is received and logged by SPHA. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

In the last 12 months, have you paid any medical expenses for which YOU were totally responsible? **YES** **NO**
If yes, please provide receipts for non-covered medications, or medical expenses, a pharmacy print-out showing your payment, canceled checks, OR a 12 month account statement from the provider.

Unless revoked in writing by me, this Authorization will expire six (6) months from the date of my signature below.

I understand that my health care providers cannot disclose the requested information without my signature on this Authorization, and that my signing or refusal to sign this authorization will not affect my ability to receive treatment from my health care providers.

I understand that I am entitled to receive a copy of this authorization.

I have the right to refuse to sign this authorization. I understand the potential exists for the information used or disclosed pursuant to this Authorization to be re-disclosed by the recipient and no longer be protected by federal law.

I have reviewed and understand this Authorization.

______________________ ______________________ ______________
Signature of Head of Household Printed Name Date Signed

______________________ ______________________ ______________
Signature of Other Adult Printed Name Date Signed

List all Health Care Providers whom you pay out of pocket that the SPHA may contact to verify your household's medical expenses. Do not list health care providers whose services are covered entirely by insurance, or to whom you do not owe any amount.

Type of Expense	Name of the Provider You Pay for this Expense	Complete Mailing Address	Phone/Fax Number	Amount Paid "Out of Pocket"
☐ Insurance ☐ Prescriptions/Medications ☐ Doctor/Dental/Hospital ☐ Care of an Assistance Animal ☐ Other				
☐ Insurance ☐ Prescriptions/Medications ☐ Doctor/Dental/Hospital ☐ Care of an Assistance Animal ☐ Other				
☐ Insurance ☐ Prescriptions/Medications ☐ Doctor/Dental/Hospital ☐ Care of an Assistance Animal ☐ Other				
☐ Insurance ☐ Prescriptions/Medications ☐ Doctor/Dental/Hospital ☐ Care of an Assistance Animal ☐ Other				

If you have more health care providers than you can list here, please make a copy of this sheet, or contact the SPHA for additional copies.

PART V. FAMILY INCOME

Please check ANY of the following types of income that ANY members of your household <u>now receive</u> or <u>expect to receive in the next twelve (12) months:</u>

___ UNEMPLOYMENT COMPENSATION
___ ANNUITY PAYMENTS
___ RETIREMENT PENSION
___ EMPLOYMENT/WAGES
___ CHILD SUPPORT
___ EDUCATIONAL GRANTS
___ VETERAN'S BENEFITS
___ PUBLIC ASSISTANCE (TANF)
___ SELF-EMPLOYMENT INCOME
___ ALIMONY
___ S.S.I.
___ SOCIAL SECURITY
___ WORKMAN'S COMPENSATION
___ OTHER (INCLUDING GIFTS, UNDER THE TABLE, ILLEGAL, ETC.)

On the chart below list all sources and gross amounts of money received by any or all members of your household.

Member Name	Employee Wages		Unemployment Compensation	Welfare (TANF)	Child Support	Social Security/SSI	Other (Explain)
	$ / hr	# hrs/week					

Does anyone outside of your household pay any of your bills or give **you or any household member** money? **YES** **NO**
If yes, how much is given? _____
Who gives it? _____
How often is it given? _____

Although we will verify your employment information on another form, please list the Employer Information below.

Person Employed: _____
Employer's Name: _____
Address: _____
City, State, Zip: _____
Telephone #: _____
Fax #: _____

Person Employed: _____
Employer's Name: _____
Address: _____
City, State, Zip: _____
Telephone #: _____
Fax #: _____

Are you currently looking for employment? **YES** **NO**
When and where you were most recently employed? _____

Are you interested in being contacted by vendors performing work for the housing authority? **YES** **NO**
If yes, what kind of work would you like to do? _____
What are your skills or training? _____

Are you an owner or co-owner in any business or real estate? **YES** **NO**
If yes, what is the name of the business? _____

I/we certify that this Family Income information given to the St. Petersburg Housing Authority is TRUE and ACCURATE and COMPLETE. I know I am required to report, <u>in writing</u>, any changes in income <u>within ten (10) days</u>. I/we understand that any <u>misrepresentation</u> on my/our part will result in my/our housing assistance being <u>terminated</u>, and the possibility of <u>criminal charges</u> on the basis of fraud. THIS MUST BE SIGNED IN THE PRESENCE OF AN SPHA REPRESENTATIVE OR A NOTARY.

_____ _____ _____
SIGNATURE, HEAD OF HOUSEHOLD PRINT NAME DATE

_____ _____ _____
SIGNATURE, OTHER ADULT PRINT NAME DATE

_____ _____ _____
SIGNATURE, OTHER ADULT PRINT NAME DATE

I certify that I have reviewed the information on Family Income for completeness and accuracy and am acting in accordance with Section 8 procedure.

_____ _____ _____
SIGNATURE, SPHA REPRESENTATIVE PRINT NAME DATE

PART VI. FAMILY ASSETS

List all assets held by all household members. If you are unsure where to place an asset please list it in "other."
List all vehicles owned **or co-owned** by all members of your household.

Make/Model	Year/Color	VIN	License Plate Number

Please attach copies of your current statements for all assets listed.

Type of Asset	Do you have?	House-hold Member	Account #	Name and complete mailing address of bank, brokerage, or company	Value or Balance
Checking	☐ **Yes** ☐ **No**				
Savings	☐ **Yes** ☐ **No**				
Money Market	☐ **Yes** ☐ **No**				
Stocks/Bonds/ Annuities/CDs	☐ **Yes** ☐ **No**				
IRA/KEOGH/ Retirement	☐ **Yes** ☐ **No**				
Trust	☐ **Yes** ☐ **No**				
Life Insurance	☐ **Yes** ☐ **No**				
Other (Specify)	☐ **Yes** ☐ **No**				
Other (Specify)	☐ **Yes** ☐ **No**				

Please circle "YES" or "NO" to the following questions.

Have you disposed of, sold, or given away any assets for less than the Fair Market Value during the past two (2) years? **YES** **NO**

If yes, please complete the following:

1) Type of asset: _____ 3) Amount received: $_____

2) Date of disposal: _____ 4) Market value when disposed: $_____

Do you own, or are you purchasing a house, mobile home, or any other form of real estate? **YES** **NO**

Mortgage Company: _____

Address: _____

PART VII. EDUCATION

Do any household members 18 or older attend school or college? If YES, please list below. (circle) **YES** **NO**

Household Member	Name of School	Grade	Full or Part Time

Use additional sheets if necessary. For each student, please supply: all Financial Aid letters, proof of registration and proof of the amount of tuition from the school.

PART VIII. AUTHORIZATION

Client gives consent and authorizes SPHA and all of SPHA's representatives to make any and all inquiries necessary to verify the information provided herein. This information includes, but is not limited to, direct contact with the Client's current and previous landlords, employers, credit agencies, credit references, financial institutions, and other agencies as deemed appropriate.

_____	_____	_____
SIGNATURE, HEAD OF HOUSEHOLD	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE, OTHER ADULT	PRINT NAME	DATE

I/we certify that we understand that I/we must report all changes of criminal status, income, or family size within ten (10) days of the change. I/we understand that all changes must be reported in writing. I/we understand that no person other than those listed on the housing application may occupy an assisted unit.

I/we understand that the Housing Authority is authorized to obtain criminal arrest records from law enforcement agencies to assist them in screening applicants and family members to be admitted to or remain in the program. This authority assists the housing authority in complying with HUD requirements to deny or terminate assistance to applicants or participants in the program who are engaging in or have engaged in violent criminal or drug related activities. These activities are defined by HUD located within the HUD Contract.

In signing this document I/we confirm that I/we fully comprehend and I/we do hereby swear and attest that all of the above information about me/us and all members living within my/our Subsidized Housing Unit is true and correct. I also understand that any false statements made in an attempt to receive or continue to receive public assistance benefits is a crime under Florida Statute 414.39.

<u>WARNING! Title 18, Section 1001 of the United States Code states that a person is guilty of a felony for knowingly making false or fraudulent statements to any department or agency of the United States.</u>

By my signature below, I do hereby swear and attest that all of the information reported on this form about me and my household is true and correct, and I have read agree to the certifications contained in this form. I also understand that all changes in household members or income must be reported to the Department of Housing Services in writing, immediately.

_____	_____
Signature of Head of Household	**Date**
_____	_____
Signature of Spouse or Other Adult	**Date**
_____	_____
Signature of Other Adult	**Date**
_____	_____
Signature of Other Adult	**Date**

If any section of this document is not signed in the presence of an SPHA Representative, this document <u>must</u> be signed in the presence of a notary.

NOTARY, STATE OF FLORIDA, COUNTY OF PINELLAS

The foregoing instrument was sworn to and subscribed before me this _____ day of _____ 201__ by _____. He/She ____ is personally known to me or _____ has produced an acceptable form of identification.

_____ _____

SIGNATURE, NOTARY PUBLIC PRINT NAME

My Commissioner expires: _____