Family Income, Assets and Expenses

To establish your eligibility and or continue your HUD Housing Choice Voucher assistance, please include any/all income, assets or qualified medical expenses for **EVERY PERSON** in your household on this form. All information provided will be held in confidence and will only be used for the stated purpose. Regulations require Arbor Housing and Development to obtain third party verification of all information submitted by all applicants and tenants. If additional space is needed, please attach a separate sheet of paper.

INCOME

Is income received from any of these sources?	**Family member who receives income**	**Name of company, agency, person issuing income**	**Street Address, City, State, Zip Code of company, agency, person issuing income**
Wages from employment			
Self employment			
Regular payments from a Pension, Retirement Plan, 401 K, 403 B, IRA, etc.			
Veterans Benefits			
Disability Benefits			
Alimony/Spousal Support			
Child Support received from absent parent			

Is income received from any of these sources?	**Name of family member who is entitled to the benefit**	**Social Security or claim number the benefit is issued under**	**Receive Medicare?**
Social Security Social Security Income (SSI) Social Security Disability (SSD) Children's Benefits (any benefits received on behalf of children)			Yes / No
			Yes / No
			Yes / No

Is income received from any of these sources?	**Family member who receives income**	
Child Support received from Social Service Agency		
Workers Compensation		
Unemployment Benefits		
Food Stamps		
Public Assistance/TANF		Is there a Medicaid Spenddown? Yes / No

Does anyone outside of your household pay any of your bills or give you money? Yes/No _____

If yes, please provide that persons name and address: _____

_____

_____

If an adult family member attends college, provide the name of the college student _____,

the name of the college _____ and

the address of the college _____

EXPENSES

If a childcare provider is paid so that an adult household member can work or attend school, provide the name of the childcare provider _____ and the address of the childcare provider _____.

Out-of-Pocket Medical Expenses

Only complete this section (medical expenses) if the head of household or spouse is at least 62 years of age or disabled. If the family qualifies, all "out-of-pocket" medical expenses for all family members may be counted. If additional space needed, attached a separate sheet of paper.

Medical Expenses	**Family member name**	**Name of Doctor, Pharmacy, Insurance Company, agency etc.**	**Street Address, City, State, Zip Code of Doctor, Pharmacy, Insurance Company, agency, etc.**
Services of Doctors / Health Care Professionals			
Prescription Medicines			
Dental Expenses			
Eye Care Expenses			
Hearing Aid or Other Needed Equipment			
Medical Insurance Premiums			

Live-in or periodic medical Assistance			

ASSETS

Does any family member have any of these assets?	**Family member who owns asset**	**Name of bank, company or property owner**	**Street Address, City, State, Zip Code for bank or company**
Checking Account			
Savings Account			
Holiday Club Account			
CD - Certificate of Deposit			
Lump sums taken from a Retirement Plan, Pension Plan, IRA, 401 K, 403 B			
Stock Dividends			
Real Property including Land, Building, etc.			

_____ _____

Signature of Head of Household Date

_____ _____

Signature of Spouse or Co-Head Date

_____ _____

Signature of Other Adult Date

_____ _____

Signature of Other Adult Date