Klamath Housing Authority * UPDATE APPLICATION

Please Use Ink

Name of Head of Household: _____

Present Address: _____

Mailing Address: _____ e-mail: _____

Phone Number: _____ Work # _____ Message # _____

Preferred method of contact: ☐ Phone ☐ Email

List everyone living in Household

Name First Last MI	Relation to Head	Date of Birth	Age	M or F	Student Y or N	Social Security #	Place of Birth
	Self						

****Please explain the change/Update in your household. (Change in income, change in household composition, change in address, etc.)**

Are you adding a new family member? _____Yes _____No

Name: _____

Has any member engaged in drug-related criminal activity? _____Yes _____No

What? _____ When? _____

Has any member engaged in violent criminal activity? _____Yes _____No

What? _____ When? _____

Does any member of your household have to register as a sex offender? _____Yes _____ No

Please list all checking, savings, CD, Money Market or other accounts

Name on Account	Type of Account	Name of Bank	Account Number	Approximate Amount

Income. Please list all sources of income: Employment, Self-Employment, Welfare, SSI/SSD/SSB, Social Security, Pension, Disability, Worker's Comp, Unemployment, Alimony, Child Support, Interest, Dividends, Annuities, Scholarships, Grants, any lump sum settlements, etc.

Household Member	Income Source	HR/Monthly/Annually

Do you have a Child Support Case Number? _____Yes ____ No Case #_____

Does any family member own any real estate? _____Yes _____No
Value: $_____

Since your last appointment:
Are you laid off? _____Yes _____ No Date returning to work? _____
On Maternity Leave? _____Yes _____ No Date returning to work:_____
Did you quit or get fired from a job?____Yes ____ No Date: _____

Do you pay for child care? _____Yes _____No
Cost per hour: $_____ Cost per week:$_____Cost per month:$_____
Does Welfare help pay? _____Yes _____No
Your co-pay: $_____
Child Care Provider Name: _____Phone # _____
Address: _____
_____

ELDERLY/DISABLED FAMILIES ONLY
Do you have Medicare? _____Yes _____No
If yes, what are your premiums? _____
Do you have any other kind of medical insurance? _____Yes _____No
If yes: Insurance Name _____
Address _____ Policy #_____
Premium Amount $_____
Does the state pay any of your medical expenses? _____Yes _____No
Do you make payments to a doctor, hospital or pharmacy? _____Yes _____No
Name: _____ Address: _____
Name: _____ Address: _____

PRIVACY ACT STATEMENT: The information on this form is being collected by HUD to determine the applicant's eligibility, recommended unit size, and the amount of contribution by the family. It will be used to provide the basis for managing the programs covered by this form, for protecting the government's financial interest, and for verifying the accuracy of the information furnished. It may be released to appropriate Federal, State and local agencies when relevant, to civil, criminal or regulatory investigators of prosecutors. 42 USC 1437 et reg. OHCS 1981, PL 97-35, Stat 348.408.

I/We certify that the statements above are true and complete to the best of my/our knowledge. I/We understand that false statements are punishable under Federal Law.

_____ _____
Signature of Head of Household Date Signature of other adult Date

_____ _____
Signature of Head of Household Date Signature of other adult Date