

**INCOME UPDATE
FAMILY CHANGE FORM**

Head of Household: _____

Spouse or Other Adult: _____

Address: _____

Phone number(s): _____

E-mail Address: _____

KHA's policy is rent adjustments will only be made if the decrease in annual income is more than \$2000.00, excluding families at minimum rent, zero rent, or zero income.

FAMILY COMPOSITION

Please Check One: Child Added: ____ Child Removed: ____ Adult Removed: ____

Name: _____

INCOME

Employment

Participant's Name: _____

Name of Employer: _____

Address: _____

Phone #: _____

Rate of Pay: _____ Hours per week: _____

Start date of employment: _____ End date of employment: _____

Employment

Participant's Name: _____

Name of Employer: _____

Address: _____

Phone #: _____

Rate of Pay: _____ Hours per week: _____

Start date of employment: _____ End date of employment: _____

	<u>Head of Household</u>	<u>Other Household Member(s)</u>
SS/SSI/SSDI	\$ _____	\$ _____
Pension/Retirement	\$ _____	\$ _____
AFDC/TANF	\$ _____	\$ _____
Food Stamps	\$ _____	\$ _____
Energy Assistance	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____
Workman's Comp	\$ _____	\$ _____
Child Support		
Amount received	\$ _____	\$ _____
Alimony		
Amount received	\$ _____	\$ _____

OTHER INCOME SOURCES

I have received other income or assistance in the following form:

A friend, family member or agency has helped/is helping me pay bills (rent, utilities, car payment, insurance, registration, phone, cable, internet, health insurance, etc.)

Explain: _____

Name: _____ Phone Number: _____

Address: _____

Name: _____ Phone Number: _____

Address: _____

STUDENT STATUS

<u>List all students 18 years of age or older</u>	<u>School</u>	<u>Financial Aid Amount</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

ASSETS

	<u>Head of Household</u>	<u>Other Household Member(s)</u>
Name of Bank	_____	_____
Checking	\$ _____	\$ _____
Savings	\$ _____	\$ _____
Trust Funds	\$ _____	\$ _____
Stocks or Bonds	\$ _____	\$ _____
Retirement Accts	\$ _____	\$ _____
CD's or Money	\$ _____	\$ _____
Market Accts		

DAY CARE PROVIDER

Name: _____

Address: _____

Phone Number: _____

Out of Pocket expense: _____

Amount paid by DHHS or other person: _____

OUT OF POCKET MEDICAL EXPENSES FOR ELDERLY AND DISABLED ONLY

Certified Statement: The information requested on this form is being collected in connection with regulations of the Kearney Housing Agency, Kearney, Nebraska authorized by the United States Department of Housing and Urban Development to determine an applicant's initial and continuing eligibility; apartment size; and the amount of contribution by the tenant(s). It will be used to provide the basis for managing the program(s), for protecting the United States Government and the Kearney Housing Agency'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 or prosecutors. Failure to provide any information may result in a delay, or rejection of eligibility approval, or subsequent determination that initially approved eligibility was erroneous. General authorization to request this information is based on the Authority granted by the United States Housing Act of 1937, as amended, 42U.S.C., 1437 et seq., the Housing and Community Development Amendments of 1981, P.L. 97-35. 85 Statute, 348,408.

Warning: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Applicant(s)/Tenant(s) Statement:

I do hereby swear and attest that all of the information above about me is true and correct. I also understand that information provided with this Update Form as well as third party verifications will be used to make a rent adjustment.

Participant's Signature

Date

Participant's Signature

Date

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Kearney Housing Agency does not discriminate on the basis of handicap, race, color, religion, sex, familial status, national origin, or gender identity or sexual orientation; in the admission or access to, or treatment or employment in its federally assisted programs and activities.

_____ *Equal Opportunity Housing* _____

The services of a Spanish speaking interpreter are provided to all applicants and residents with no cost to the applicant or resident.