Affordable Housing Supplemental Rental Application

Schedule T

RurAL CAP
Rural Alaska Community Action Program, Inc.

Central Leasing Office
161 Klevin St., Suite 206A
Anchorage, AK 99508
Phone: (907) 868-4600
Fax: (907) 868-4609

PLEASE READ THIS BEFORE FILLING OUT APPLICATION

If you are applying for housing at the follow properties:

- ***325 E 3rd Avenue***
- ***Muldoon Garden – 207 Muldoon Road***
- ***1255 E 11th Avenue***
- ***Huntsman Circle***

Please complete and/or sign the following forms

- ☐ Intake Assessment (pages 1-2 for Head of Household, pages 3-4 for each family member
- ☐ Homeless Verification
- ☐ Verification of Handicap or Disability
- ☐ Verification of Student Status
- ☐ Non-Employed Status Certification*
- ☐ Self-Employment Certification*
- ☐ Medical Expense Certification*
- ☐ Child Care Expense Verification*
- ☐ Marital Separation Certification*
- ☐ Minor Turning 18 within 12 months Anticipated Income*

If a form does not apply to your situation, strike a line through the page and write "N/A," sign and date.

Completed Applications* may be submitted:

1. In person: 161 Klevin St., Suite 206A, Anchorage, AK 99508
2. Via Fax: 907-868-4609
3. Email: propertymanagement@ruralcap.com

*NOTE: incomplete applications will be not be accepted

Equal Housing Opportunity Statement: We are pledged to the letter and spirit of U.S. policy for the achievement of equal housing opportunity throughout the Nation. We encourage and support an affirmative advertising and marketing program in which there are no barriers to obtaining housing because of race, color, religion, sex, disability, familial status, or national origin.

RurAL CAP Property:	☐325 E. 3rd Avenue ☐Davis ☐Karluk Manor ☐North Lane ☐Safe Harbor Muldoon ☐Peterkin ☐Sitka Place

Household Type:	☐ Couple with No Children ☐ Female Single Parent ☐ Male Single Parent ☐ Two Parent Family ☐ Grandparent(s) and Child ☐ Foster Parent(s) ☐ Non-Custodial Caregiver(s) ☐ Other: _____

For any answers below in which a client doesn't know or refuses to disclose information, please indicate **DK** (Doesn't Know) or **CR** (Client Refused).

Answer this section for each person in the household (complete additional data elements on the **Household Members** form and **Additional Adults** form). Please use additional forms for households with more than 6 people.

Client Name	SS#	Veteran?	Date of Birth	Race (see below)	Ethnicity (see below)	Gender (see below)	Relationship to Head of Household
		☐ Yes ☐ No	____/ ____/____				*Self (HoH)*
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				

Race: **Indicate Primary Race (1) & Secondary Race (2)*	**Ethnicity:**	**Gender:**
▪ American Indian / Alaska Native (*AI / AN*) ▪ Asian (*A*) ▪ Black / African American (*B / AA*) ▪ Native Hawaiian / Other Pacific Islander (*NH/PI*) ▪ White (*W*) ▪ Client doesn't know (*DK*) ▪ Client refused (*CR*)	▪ Non-Hispanic / Non-Latino (*N*) ▪ Hispanic / Latino (*H/L*) ▪ Client doesn't know (*DK*) ▪ Client refused (*CR*)	▪ Female (*F*) ▪ Male (*M*) ▪ Trans Female - Male to Female (*MTF*) ▪ Trans Male - Female to Male (*FTM*) ▪ Gender Non-Conforming (*GNC*) ▪ Client doesn't know (*DK*) ▪ Client refused (*CR*)

Residence Prior to Project Entry: (Select ***only one***, then complete the corresponding box below.)	☐Homeless Situation ☐Institutional Situation ☐Transitional or Permanent Housing Situation

Complete pages 1-2 once for whole household.

Complete pages 3-4 for each member of the household.

☐ Homeless Situation

☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher

"How long have you been in this current homeless situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Institutional Situation

☐ Foster care home or foster care group home ☐ Long-term care facility or nursing home
☐ Hospital or other residential medical facility ☐ Psychiatric hospital or other psychiatric facility
☐ Jail, prison, or juvenile detention facility ☐ Substance abuse treatment facility or detox center

"How long have you been in this institutional situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 90 days, on the night before entering the 'institutional situation,' were you **on the streets** or **in emergency shelter**?"*	☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Transitional & Permanent Housing Situation

☐ Hotel paid for without voucher ☐ Rental by client, GPD TIP subsidy
☐ Owned by client, no ongoing subsidy ☐ Rental by client, other subsidy including RRH
☐ Owned by client, ongoing subsidy ☐ Residential project, no homeless criteria
☐ Permanent housing for homeless persons- no RRH ☐ Staying or living with family
☐ Rental by client, no subsidy ☐ Staying or living with friends
☐ Rental by client, VASH subsidy ☐ Transitional housing for homeless persons

"How long have you been in this transitional or permanent housing situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 7 nights, on the night before entering the 'transitional or permanent housing situation,' were you **on the streets** or **in emergency shelter**?"*	☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

Living Situation *(Only complete if "Approximate Date Homelessness started" was answered above.)

"Regardless of where you stayed last night, <u>how many times</u> have you been **on the streets or **in emergency shelter** in the last 3 years?"*	☐ One time ☐ Two times ☐ Three times ☐ Four or more times
*"<u>How many months</u> have you been **on the streets** or in **emergency shelter** in the last 3 years?"*	☐ Fill in a number up to 12 months: _____ ☐ More than 12 months

"What is the primary reason that you are seeking assistance?"

☐ Illness/Injury
☐ Domestic Violence
☐ Hours of Work Cut
☐ House Repairs (Damaged/Destroyed)
☐ ATAP Delays/Sanction
☐ Death in Family
☐ Legal Issues
☐ Unemployed-Less than 60 Days
☐ Unemployed-More than 60 Days
☐ Nonpayment of Child Support
☐ Benefits Interrupted (i.e. SSI or VA)
☐ In Treatment
☐ Low Wages/Fixed Income
☐ Car Trouble/Accident
☐ Loss of Partner/Roommate
☐ Theft Victim
☐ Moved from w/in AK with Insufficient Funds
☐ Moved to AK with Insufficient Funds
☐ New Job/Paycheck Delay
☐ Mortgage Foreclosure
☐ Loss of Job
☐ Released from Medical Facility
☐ Released from Jail/Prison
☐ Living with Relative/Friend-Asked to Leave
☐ Substance Abuse
☐ Other (specify): _____

RurAL CAP Data Elements

CSBG Household Type:
☐ Single Person ☐ Single Parent Male ☐ Multigenerational Household
☐ Two Adults NO Children ☐ Two Parent Household ☐ Other
☐ Single Parent Female ☐ Non-Related Adults with Children ☐ Unknown / Not Reported

Education Level:
☐ Grades 0-8 ☐ High School Graduate / Equivalency Diploma ☐ 2 or 4 Year College Graduate
☐ Grades 9-12 / Non-Graduate ☐ 12 Grade + Some Post-Secondary ☐ Graduate of Other Post-Secondary School
☐ Unknown / Not Reported

If Youth is 14-24, are they working or going to school? ☐ Yes ☐ No

Primary Language:

Secondary Language (if applicable):

Oral English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

Written English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

Do you require assistance with English?	If Yes, do materials need to be translated?	If assistance is required, who do you want to interpret for you?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Family member ☐ SHD Provided Interpreter ☐ Friend ☐ Other: _____

Health Insurance (Check all that apply.)

Is the client covered by health insurance?
☐ Yes ☐ No
☐ Client doesn't know
☐ Client refused

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance Program
☐ Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance
☐ Health Insurance obtained through COBRA
☐ Private Pay Health Insurance
☐ State Health Insurance for Adults
☐ Indian Health Services Program
☐ Other: _____

Disabilities (Check all that apply.)

Does the client have a disabling condition?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

Disability Type	Long-Continued and Indefinite Duration?
☐ **Alcohol Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Both Alcohol & Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Chronic Health Condition**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Developmental**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **HIV/AIDS**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Mental Health Problem**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Physical**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Alaska Mental Health Trust (AMHT) Beneficiary (Select an answer for each disability type.)

Does the client have any of the following disabilities?

Alzheimer's Disease and Related Dementias	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Chronic Alcoholism or other Substance Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Intellectual or Developmental Disabilities	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Mental Illness	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Traumatic Brain Injuries	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Primary Alaska Native Regional Corporation

☐ Not Affiliated

☐ Ahtna Corp. ☐ Calista Corp. ☐ NANA Regional Corp.
☐ Aleut Corp. ☐ Chugach Alaska Corp. ☐ Sealaska
☐ Arctic Slope Regional Corp. ☐ Cook Inlet Regional Corp. ☐ 13th Regional Corp.
☐ Bering Straits Native Corp. ☐ Doyon Limited Corp. ☐ Client doesn't know
☐ Bristol Bay Native Corp. ☐ Koniag Incorp. ☐ Client refused

Secondary Alaska Native Regional Corporation (if applicable): _____

For Permanent Housing Projects—including Rapid Rehousing Projects—*only*

Please note that if you are completing this for a project that is not a permanent housing project and this data element is filled in on the Entry Assessment in HMIS for this client, remove it on the Entry Assessment.

Housing Move-In Date: _____/ _____/ _____

RurAL CAP Data Elements

Military Service? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Not Applicable

If Yes for Military Service:

☐ Active Duty, Combat	☐ Gulf War, Combat	☐ Reserves / Nat'l Guard, Combat	☐ Vietnam, Combat
☐ Active Duty, Noncombat	☐ Gulf War, Noncombat	☐ Reserves / Nat'l Guard, Noncombat	☐ Vietnam, Noncombat
☐ Afghan War, Combat	☐ Iraq War, Combat	☐ Retired, Combat	☐ Veteran, Other Eras
☐ Afghan War, Noncombat	☐ Iraq War, Noncombat	☐ Retired, Noncombat	

Work Status:

☐ Employed Full-Time	☐ Unemployed (Long-Term, More than 6 Months)
☐ Employed Part-Time	☐ Unemployed (Not in Labor Force)
☐ Migrant Seasonal Farm Worker	☐ Retired
☐ Unemployed (Short-Term, 6 Months or Less)	☐ Unkown / Not Reported

If Employed:

Length of Employment:
Employed by:
Employer's Address:
Employer's Phone Number:
Position Held:

Monthly Income (Select the specific sources and specify the monthly amount of each source.)

Does the client have a source of income?
☐ Yes ☐ No
☐ Client doesn't know
☐ Client refused

If yes, what is the total monthly income?

$_____

☐ Alimony/Other spousal support	$	☐ SSDI	$
☐ VA service connected disability compensation	$	☐ SSI	$
☐ VA non-service connected disability pension	$	☐ General assistance	$
☐ Worker's Compensation	$	☐ Unemployment insurance	$
☐ Retirement income from social security	$	☐ TANF	$
☐ Pension/Retirement income from another job	$	☐ Child support	$
☐ Private disability insurance	$	☐ Earned income	$

Level of Household Income:

☐ Up to 50%	☐ 76% to 100%	☐ 126% to 150%	☐ 176% to 200%	☐ 251% and Over
☐ 51% to 75%	☐ 101% to 125%	☐ 151% to 175%	☐ 201% to 250%	☐ Unknown / Not Reported

Non-Cash Benefits (Check all that apply.)

Does the client receive non-cash benefits?
☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

☐ TANF Child Care Services	☐ SNAP (Food Stamps)
☐ TANF Transportation Services	☐ Special Supplemental Nutrition Program for WIC
☐ Other TANF-Funded Services	☐ Other (specify): _____

Domestic Violence Victim / Survivor

"Are you a victim or survivor of domestic violence?"	☐ Yes	☐ No	☐ Client doesn't know	☐ Client refused
If yes, when did the last experience occur?	☐ Within the last 3 months	☐ 6-12 months ago	☐ 1+ years ago	☐ Client doesn't know ☐ Client refused
If yes, is the client currently fleeing the DV situation?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client refused

Applicant Name: _____

Homeless applicants who meet the criteria described below must provide certification of homeless status from a public or private facility that provides shelter for such households, or from the local police department, or any social service agency that provides services for homeless people. In order to verify an applicant's homelessness please fill out the following form:

1. Applicant is "Homeless" (choose one of the following *or* select one from item 2):

   ☐ Moving from an emergency shelter

   ☐ Moving from Transitional Housing

   ☐ An individual who lacks a fixed, regular, and adequate nighttime residence

   Does the Applicant also meet the Chronic Homeless Definition?

   HUD has defined chronic homelessness as a individual or family with a disabling condition who has been continuously homeless for a year or more or has had a least four episodes of homeless in the past three years <u>where those episodes cumulatively total at least 12 months</u> and is living in an emergency shelter or a place not meant for human habitation.

   ☐ Yes

   ☐ No

2. Applicant is "At Risk of Homelessness" (if no item from #1 has been checked choose one of the following):

   ☐ Households with income at or below the greater of 20 percent of State Median Income (SMI) or Area Median Income (AMI) with no rental subsidy available to the household.

   ☐ Households with incomes above 20 percent but not exceeding 30 percent of the greater of SMI or AMI:

   AND (check all that apply)

   ☐ Face immediate eviction and have been unable to identify a subsequent residence.

   ☐ Face imminent release from an institution (i.e.; jail, hospital foster care system) where other housing placement resources are not available

   ☐ Reside in an overcrowded setting (more than two persons per living/sleeping area) in which the household does not hold a lease.

   ☐ Reside in substandard housing subject to a current official vacation notice.

   ☐ Pay more than 50 percent of income in housing costs.

3. Please provide documentation **or** certification of homelessness **(choose A or B).** Certifications can be made by a shelter provider, other social service provider or outreach worker.

A. I _____ from (agency)

_____ verify that

_____ (applicant) meets the criteria for homelessness

Checked above (items 1). Documentation is available at:

_____ (agency), located at:

_____, _____, _____

Street City State/Zip

B. The following documentation is need for people <u>at risk of homelessness.</u> (Please note: all elements of the definitions must be met. For example, a notice of eviction is not sufficient while a notice of eviction plus income verification documenting the potential tenant has income of less than 30% of AMI is sufficient.)

- ☐ Notice of eviction
- ☐ Notice pay rent or quit within 14 days
- ☐ Receipt of payment (SRO or Motel)
- ☐ Documentation of substandard housing
- ☐ Release papers (jail, hospital, or foster care system)
- ☐ Rent receipt with proof of income
- ☐ _____ (other).

4. Please sign and date.

Agent Signature: _____ Date: _____

Phone Number: _____

(Sponsor, Service Provider or Property Management Company Name)

Representative: _____ Date: _____

Phone Number: _____

Warning: Title 18, Section 1001, 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.

HOMELESS DEFINITION AND RECORDKEEPING REQUIREMENTS

Criteria for Defining Homelessness	Literally Homeless	(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
	Imminent Risk of Homelessness	(2) Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Recordkeeping Requirements	Literally Homeless	• Written observation by the outreach worker; or • Written referral by another housing or service provider; or • Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter; • For individuals exiting an institution-one of the forms of evidence above and ○ Discharge paperwork or written/oral referral, or ○ Written record of intake worker's due diligence to obtain above evidence and certification by that individual that they exited the institution
	Imminent Risk of Homelessness	• A court order resulting from an eviction action notifying the individual or family that they must leave; or • For individual and families leaving a hotel or motel-evidence that they lack the financial resources to stay; or • A document and verified oral statement; and • Certification that no subsequent residence has been identified; and • Self-certification or other written documentation that the individual lack the financial resources and support necessary to obtain permanent housing

2018 AREA INCOME GUIDELINES AS DEFINED BY HUD

2018 Area Median Income Guide	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
Median (100%)	$50,350	$57,500	$64,700	$71,900	$77,650	$83,400	$89,150	$94,900
30%	$20,850	$23,800	$26,800	$31,380	$36,780	$42,180	$47,580	$52,980

Explanation to Third Party Completing Form

Please identify any of the relevant definitions that apply to the individual. Any other request for information about the individual is not relevant (e.g., diagnosis, treatment plan). HUD requires the housing owner/operator to verify all information that is used in determining this person's eligibility or level of benefits.

Applicant: _____

For each item below, please check YES or NO to the statement that accurately describes the person listed above.

☐ YES ☐ NO 1. Has a disability, as defined in 42 U.S.C. 423, which means; [1]

a. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; and
b. Determination of disability should include the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity.

☐ YES ☐ NO 2. Has a physical, mental or emotional impairment that:

a. is expected to be of long-continued and indefinite duration;
b. substantially impedes the person's ability to live independently; and
c. is such that the person's ability to live independently could be improved by more suitable housing conditions (e.g., a substance abuse disorder if the person's impairment could be improved by more suitable housing conditions); [2]

☐ YES ☐ NO 3. Has a developmental disability as defined by the Developmental Disability Assistance and Bill of Right Act (42 USC 60011 (7) generally provided as follows: A severe, chronic disability which:

a. is attributable to mental and /or physical impairments or combination of mental and physical impairments;
b. was manifested before age 22;
c. is likely to continue indefinitely;
d. results in substantial functional limitations in 3 or more of the following areas of major life activity:
    i. Self-care,
    ii. Receptive and expressive language,
    iii. Learning,
    iv. Mobility,
    v. Self-direction,
    vi. Capacity for independent living, and
    vii. Economic self-sufficiency; and
e. reflects the person's need for a combination and sequence of special, interdisciplinary, or general medical or psychiatric care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

☐ YES ☐ NO 4. Has a chronic mental illness, i.e., if he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently (e.g., by limiting functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc.) and whose impairment could be improved by more suitable housing conditions.

NOTE: Key to the definition of disability is determining that the impairment is of long-continued and indefinite duration AND **substantially impedes** the person's ability to live independently. For example, drug or alcohol abuse or an HIV/AIDS condition that **does not** substantially impede a person's ability to live independently does not qualify as a disability in these housing programs.[3] The determination must also take into consideration the combined effect of all the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. (See Item 1 (b) above)

Verified: _____ Date _____
Signature & Credentials

_____
Name and Title (print or type)

_____
Agency

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY STUDENT

TO: (Name & address of Educational Institution) Date: _____

_____

_____

_____

RE: _____ _____ _____
Applicant/Tenant Name | Social Security Number | Unit # (if assigned)

I hereby authorize release of my financial information.

_____ _____
Signature of Applicant/Tenant | Date

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and greatly appreciated.

_____
Project Owner/Management Agent

MAIL OR FAX THIS FORM TO:

THIS SECTION TO BE COMPLETED BY EDUCATIONAL INSTITUTION

Is the above-named individual a student at this educational institution? YES NO

If so, part-time or full-time? PART-TIME ☐ FULL-TIME ☐

If full-time, the date the student enrolled as such: _____

Expected date of graduation: _____

Total scholarships, grants, etc. *(public or private, excluding student loans)* received is:

	Amount	Beginning Date	Ending Date
Scholarships			
Grants			
Cost of Tuition			

I hereby certify that the information supplied in this section is true and complete to the best of my knowledge.

_____ _____ _____
Signature | Printed Name and Title | Date

_____
Employer [Company] Name and Address

_____ _____ _____
Phone # | Fax # | E-mail

NOTE: 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.

Name:	Telephone Number:
☐ Initial Certification ☐ Re-Certification ☐ Other: _____	Property/Unit #:

I confirm that: (initial the box the applies)

	• I am not currently employed in any capacity • I have no intention of becoming employed in the next 12 months • I do not receive unemployment compensation or other benefits as a result of my non-employment status • I am not under any other obligation to obtain employment • The reason I am not seeking employment is:_____

OR

	• I am not presently employed but I anticipate becoming employed in the next 12 months • Based on my educational background, prior experience and career training, I anticipate starting employment as a _____ • I anticipate earning $ _____ per hour working _____ hours per week • I anticipate starting employment on _____
	This information is supported by the attached documentation: _____ Previous year's tax returns _____ Previous job and salary history _____ Written confirmation from a new employer _____ Three current employment advertisements showing average compensation _____ Other _____

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. I understand that providing false representations herein constitutes an act of fraud. I understand that this certification and supporting documentation is made as part of the qualification procedure to determine eligibility for residency and providing false, misleading or incomplete information may result in the termination of a lease agreement.

_____ _____

Signature of Applicant/Resident/Tenant Date

Name:	Telephone Number:
☐ Initial Certification ☐ Re-Certification ☐ Other: _____	Property/Unit #:

I am an applicant/resident/tenant of a development that operates under the _____ program. A requirement of this program is the verification of all income and assets to determine eligibility.

Please complete the following:

Business Name	
Taxpayer ID#	
Business Address	
Telephone Number	
Date Opened	
Last Year's Income (past 12 months)	
Anticipated Income (next 12 months)	
Frequency of Pay	
Has been continuous (i.e. months per year)?	

Please check the box next to the statement that applies to your situation:

	Attached is a complete copy of my signed federal income tax return (along with the appropriate schedules) for the most recent tax filing year
	Attached is an anticipated Profit and Loss Statement completed by an accountant or tax attorney for my new business (have not filed tax returns yet).
	Attached is an anticipated Profit and Loss Statement that I have completed for my new business (have not filed tax returns yet).

_____ **I understand that I will be required to submit my Federal Income Tax Return including a Profit and Loss Statement at my next scheduled annual recertification.**

Initials

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

_____ _____ _____

Signature of Applicant/Resident/Tenant | Printed Name of Applicant/Resident/Tenant | Date

Re: _____ Unit/Property: _____

Name of Medical Professional: _____

Address: _____Phone: _____

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months.

Signature_____Date_____

The individual referenced above is a participant in a federally assisted housing program. Federal regulations require that we verify out-of-pocket medical expenses paid by household. The amounts provided must be paid out-of-pocket by the participant and may not be reimbursed from another source. Thank you for your assistance.

Area below to be completed by Medical Care Professional
(Please answer all questions. Answer N/A if the question doesn't apply.)

We ask your cooperation in providing the following information and returning to our offices. Your prompt return of this information will help to ensure timely processing of the application. The applicant/tenant has consented to this release of information as shown below.

The information provided is for the 12- month period of _____to _____

Total amount of actual out of pocket medical expenses, not covered by insurance, paid in the 12- month period listed above: $ _____

Does the above-named Applicant/Tenant owe you an outstanding balance that the individual listed above is making payment on a payment plan: _____ Yes _____ No

If yes, what is the current balance: $ _____

What is the amount regularly paid: $ _____ per _____.

_____ _____
Name and Title of Person Supplying the Information Firm/Organization Name

_____ _____
Signature Date

Return this form to:
RurAL CAP – Attn: Supportive Housing – 731 E 8th Avenue – Anchorage, AK 99501
Phone: (907)279-2511 Fax: (907)278-2309

Re: _____ Unit/Property: _____

The individual referenced above is a participant in a federally assisted housing program. Federal regulations require that we verify expenses paid for the care of dependent children enabling the family member to be employed or to attend school. The amounts provided must be paid out-of-pocket by the participant and may not be reimbursed from another source. Thank you for your assistance.

By signing below I authorize the release of this information and certify that I am not reimbursed from any source for the amount paid.

_____ _____

Participant's Signature Date

By signing below, I certify that I provide child care services for the above-referenced participant and receive the amount of compensation stated. Please complete all information requested.

Names of children care is provided for:	Ages:

Do you receive co-payments from the state or any other source for this participant's child care? ___Yes __No

If yes, base amount $_____ Participant portion $_____ Co-payment portion $_____

I receive $_____ each **week** for services ***OR*** I receive $_____ each **month** for services.

Date you began to provide child care for this participant: _____

Number of hours child care is provided each day: _____

If the amounts received differ for child care received during holidays, vacations, etc., please provide dates and amount received: _____

I certify that this information is accurate.

_____ _____

Signature of Child Care Provider Name (print)

_____ _____

Agency Name (if applicable) Telephone Number

_____

Address City State Zip

Return this form to:

RurAL CAP – Attn: Supportive Housing – 161 Klevin Street, Suite 206A – Anchorage, AK 99508
Phone: (907)868-4600 Fax: (907)868-4609 email: propertymanagement@ruralcap.org

Household Name: _____ Property/Unit #:_____

Applicant/Resident Name:_____ Spouse Name:_____

If you are currently separated from your spouse, this form must be completed.
Choose and complete the appropriate statement below:

Part I: Marital Status

☐ 1. I am currently legally separated from my spouse.

☐ 2. I am currently, but not legally, separated from my spouse. I began the legal process on _____(date) and I anticipate this separation to be permanent.

☐ 3. I am currently, but not legally, separated from my spouse effective _____(date) and I have not begun the legal process for the following reason(s).

☐ Financial reasons
☐ Incarceration/Protective Custody
☐ Other (explain):_____
☐ Responsible party is deceased
☐ Responsible party's location is unknown

Documentation regarding the estrangement **must** be attached. May utilize one of items #1-3 **or** two documents from items #4-8:

1. Certified filed copy of divorce petition or legal separation documents;
2. Documentation from an attorney or legal aid office indicating that the individual is pursuing a divorce or legal separation;
3. Copy of legal restraining order or documentation that individual has experienced domestic violence;
4. Letter on business letterhead from a reputable third party who can confirm in their professional capacity (ex. marriage counselor, attorney, employer, landlord, etc.) that the marital separation is permanent;
5. Legal or official documents indicating separate residency which have the individual's name only and the spouse's name only (i.e. current lease/rental/mortgage documents or separate utility bills);
6. Copy of the tax return and evidence of filing for the previous year's tax return indicating a filing status other than married filing jointly;
7. A letter from a social agency, such as the Department of Human Services, stating that they are aware of the separation, and according to their files, the individual is considered as such for their programs.
8. A personalized letter from the individual describing the situation and the reasons why he/she is unable to provide any of the required supporting documentation (This option is only available to those separated less than a year).

Part II: Financial Support (check all that apply)

☐ I am currently receiving or anticipate receiving $_____ per_____(frequency) from my spouse during the next 12 months.

☐ I am not currently and do not seek or anticipate receiving any compensation from my spouse during the next 12 months.

☐ My spouse and I have the following shared assets:_____

☐ My spouse and I do NOT have shared assets.

Part III: Household Composition

The following list includes all persons who will live in the unit:

_____

_____

_____

_____

I understand no adults can be added to my household in the first year of residency. I agree that if my spouse and I reconcile and become a household the entire family must qualify as a new move-in including income eligibility. My spouse will not live in the unit until the eligibility process is complete and we are informed of approval by Cook Inlet Housing Authority. Should my family not qualify as a new move in including income eligibility then my family will vacate the premises within 10 days of notification.

Under penalty of perjury, I certify that the information presented in this Certification is true and accurate to the best of my knowledge. I consent to release such information in order to comply with government regulations regarding affordable housing programs. I further understand, that providing false representation herein constitutes an act of fraud and may lead to criminal penalties. False, misleading, or incomplete information may also result in the termination of my lease agreement.

_____

Signature of Applicant/Tenant Printed Name of Applicant/Tenant Date

State of Alaska

Before me personally appeared _____who acknowledged to me that he/she executed the

foregoing instrument this _____day of _____, 2_____.

_____

Notary Public

_____

My Commission Expires

Applicant/Tenant:_____ Unit/Property: _____

Name of Minor Turning 18: _____

Check All That Apply Regarding The Above Minor:

☐ Is not receiving earned income at this time and do not expect to receive earned income in the next 12 months.

☐ Is not receiving earned income at this time and do not know if I will receive earned income in the next 12 months.

☐ Is not receiving earned income at this time but expect to begin receiving earned income on _____(date) as a _____(work type) at $_____(per hour) for _____ (# of hours per week).

☐ Is currently receiving earned income of $_____ (per hour) as a _____ (work type) for _____(# of hours per week) and expect this income to continue for the next 12 months.

☐ Is currently attending school at _____and plan on graduating on:_____.

☐ Other: _____.

Under penalty of perjury, I certify that the information presented in this Certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representation herein constitutes an act of fraud and may lead to criminal penalties. False, misleading, or incomplete information may result in the termination of the lease agreement.

_____ _____ _____

Signature of Applicant/Tenant Printed Name of Applicant/Tenant Date

Return this form to:
RurAL CAP – Attn: Supportive Housing – 731 E 8th Avenue – Anchorage, AK 99501
Phone: (907)279-2511 Fax: (907)278-2309

Document tracking:

Date	Name	Title	Action
08.26.2016	Pam Wicks	Program Compliance Coordina	Create document

ANNUAL STUDENT CERTIFICATION
(This form must be completed by each adult household member)

NAME: _____ UNIT # _____

UNIT DESIGNATION ☐ LIHTC ☐ HOME ☐ LIHTC & HOME

Complete the following if occupying a LIHTC unit

YES	NO	
☐	☐	Will all of the persons in your household be or have they been full-time students (Kindergarten and higher. Examples: Elementary, High School, College/University, trade school, etc.) during five (5) calendar months of the current and/or upcoming calendar year? (*Please note that the five calendar months do not have to be consecutive*)

If you answered NO to this question please proceed to the bottom of the questionnaire and sign and date.

If you answered YES to this question please specify which of the following exceptions your household meets.

☐	☐	Are you receiving assistance under Title IV of the Social Security Act (AFDC/TANF)?
☐	☐	Are you enrolled in a job training program receiving assistance through the Job Training Participation Act (JTPA) or other similar program?
☐	☐	Are you married and filing a joint tax return
☐	☐	Are you a single parent with a dependent child or children and neither you nor your child(ren) are dependent(s) of another individual other than a parent of such children
☐	☐	Are you a student who was previously under the care and placement responsibility of the state agency responsible for administering a plan under part B or part E of title IV of the Social Security Act

If none of the above five (5) exceptions have been identified, the household does not qualify to reside in a LIHTC unit.

Complete the following if occupying a HOME unit

YES	NO	
☐	☐	Are you a student at an institution of higher education (including but not limited to post-secondary colleges / universities and vocational institutes)?

If you answered NO to this question please proceed to the bottom of the questionnaire and sign and date.

If you answered YES to this question please specify which of the following exceptions your household meets.

☐	☐	Are you over the age of 24?
☐	☐	Are you a veteran of the United States military?
☐	☐	Are you married?
☐	☐	Do you have a dependent child?
☐	☐	Have you been independent of your parents for at least one year? *(emancipated minor or youth aging out of foster care)*

If none of the above five (5) exceptions has been identified, the household must income qualify including the income and assets of their parents.

UNDER PENALTIES OF PERJURY, I CERTIFY THAT THE INFORMATION PRESENTED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY/OUR KNOWLEDGE. THE UNDERSIGNED FURTHER UNDERSTANDS THAT PROVIDING FALSE REPRESENTATIONS HEREIN CONSTITUTES AN ACT OF FRAUD. FALSE, MISLEADING OR INCOMPLETE INFORMATION WILL RESULT IN THE DENIAL OF APPLICATION OR TERMINATION OF THE LEASE AGREEMENT.

_____ _____ _____

PRINTED NAME OF APPLICANT/TENANT SIGNATURE OF APPLICANT/TENANT DATE

_____ _____

WITNESSED BY (SIGNATURE OF OWNER/REPRESENTATIVE) DATE