



608 Pine Street / P.O. Box 928 • Sault Ste. Marie, Michigan 49783  
PHONE 906/635-5841 • FAX 906/635-9500 • TDD No. 1-800-545-1833 Ext. 429 • www.saulthousing.com

## **4-FORMS COVER SHEET** **FOR INTERIM REEXAMINATION**

**Instructions:** Complete only the sections of this cover sheet that apply to the recent changes in your household. **The attached 4-forms still must be completed in full.** Please include documentation to verify the reported change (*e.g. pay stubs, social security benefit letter, birth certificate, unemployment benefit letter, etc.*). Use blue or black ink to fill out the forms.

**Head of Household:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

I am reporting changes for household member(s): \_\_\_\_\_

### **TYPE OF CHANGE:**

Increased Income    Decreased Income    Assets   Effective date of change: \_\_\_\_\_

### **REASON FOR CHANGE:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Started Working at: _____     | <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Veteran Benefits          |
| <input type="checkbox"/> Stopped Working at: _____     | <input type="checkbox"/> Self-Employment       | <input type="checkbox"/> Pension Benefits          |
| <input type="checkbox"/> Employment Wages              | <input type="checkbox"/> Social Security/SSI   | <input type="checkbox"/> DHHS Food/Cash Assistance |
| <input type="checkbox"/> Employment Hours              | <input type="checkbox"/> Child Support         | <input type="checkbox"/> 401(k)/Retirement Plan    |
| <input type="checkbox"/> Other (please specify): _____ |  |  |

Additional Comments:

---

---

---

---

(continued on back page)

**CHILD CARE:**

- Started Paying Out-of-Pocket Child Care Expenses
- Stopped Paying Out-of-Pocket Child Care Expenses
- New Child Care Provider:

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**HOUSEHOLD/LEASE REVISIONS:**

- Add a household member (Note: Unless the new household member is a newborn, adult members **may not** move into the home until their housing application has been processed and approved by the Sault Ste. Marie Housing Commission):

Proposed date of move-in: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name of new family member: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Reason for request to add: \_\_\_\_\_

- Remove a household member:

Household member to be removed: \_\_\_\_\_  
Effective date of move out: \_\_\_\_\_  
Reason for request to remove: \_\_\_\_\_

**OTHER HOUSEHOLD CHANGES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PERSONAL DECLARATION/4-FORMS

**ALL CHANGES MUST BE SUBMITTED WITHIN TEN (10) BUSINESS DAYS. PLEASE COMPLETE THESE FORMS USING BLUE OR BLACK INK—PENCIL IS NOT PERMITTED. EACH HOUSEHOLD MEMBER MUST USE THEIR LEGAL NAME, AND ALL ADULT MEMBERS MUST SIGN AND CERTIFY THE INFORMATION PROVIDED.**

**I. HOUSEHOLD COMPOSITION:** Please list the Head of Household, followed by the names of all individuals currently living or who will be living in your home.

ADULT(S) LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER
		<b>HEAD</b>	
CHILDREN (LIVING IN THE HOME AT LEAST 50% OF THE TIME)	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SCHOOL NAME

**IF YOU ARE SEPARATED, DIVORCED, OR THE CHILD'S OTHER PARENT IS NOT LIVING IN THE HOME, PROVIDE THEIR NAME, ADDRESS, AND ANY INCARCERATION INFORMATION, IF APPLICABLE.**

\_\_\_\_\_  
NAME

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY, STATE ZIP

\_\_\_\_\_  
PARENT OF (CHILDS NAME)

\_\_\_\_\_  
NAME

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY, STATE ZIP

\_\_\_\_\_  
PARENT OF (CHILDS NAME)

**II. CURRENT HOUSEHOLD INCOME:** Include your current household income in the spaces below:

<p><b>Employed:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Name of Employer: _____</p> <p>Gross Wages: _____</p> <p>Frequency: _____</p> <p><b>Food Assistance (DHHS):</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p> <p><b>Cash Assistance (DHHS):</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p> <p><b>SSI/Social Security:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p>	<p><b>Child Support:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is there a court order? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>For which child(ren): _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p> <p><b>Unemployment Benefits:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p> <p><b>Alimony:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p> <p><b>Other Income (specify):</b> _____</p> <p>Household Member: _____</p> <p>Gross Amount: _____</p> <p>Frequency: _____</p>
--	---

**III. ASSETS:**

1. Does anyone own or have an interest in real estate or a mobile home? Yes  No   
 If yes, list the address and State Equalized Value (SEV): \_\_\_\_\_
  
2. Has anyone disposed of any real estate or assets in the last two (2) years? Yes  No   
 If yes, please specify: \_\_\_\_\_
  
3. Does any household member have a savings, checking, or prepaid funeral account? Yes  No   
 If yes, specify the household member(s), financial institution, and account number: \_\_\_\_\_  
 \_\_\_\_\_
  
4. Does any household member own any stocks, bonds, or certificates of deposits? Yes  No   
 If yes, provide details: \_\_\_\_\_
  
5. Does any household member have a trust, retirement account, IRA, 401(k), pension, investment account, or whole life insurance? Yes  No   
 If yes, please specify: \_\_\_\_\_
  
6. Please provide the following information for any vehicle(s) that will be on the property:  
**Vehicle #1:** Make/Model: \_\_\_\_\_ License Plate: \_\_\_\_\_ Color: \_\_\_\_\_  
**Vehicle #2:** Make/Model: \_\_\_\_\_ License Plate: \_\_\_\_\_ Color: \_\_\_\_\_

**IV. GENERAL INFORMATION:**

1. Does anyone outside your household pay your bills or give you money on a **regular basis**?  
Yes  No  If yes, specify who, the amount, and the frequency: \_\_\_\_\_  
\_\_\_\_\_
2. Have you or any other adult members ever used any other name(s) or Social Security number(s) besides the one currently in use? Yes  No  If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
3. Have you or any household members ever lived, or are currently living, in subsidized (rent-assisted) housing? Yes  No  If yes, when and where: \_\_\_\_\_  
\_\_\_\_\_
4. Have you or anyone in your household been arrested or convicted of any crime, other than traffic violations, in the past **three (3) years**? Yes  No  If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
5. Has anyone in your household ever committed fraud in a federally assisted housing program or been asked to repay money for knowingly providing false information in such programs? Yes  No  If yes, please explain to whom and why: \_\_\_\_\_  
\_\_\_\_\_
6. Do you pay any out-of-pocket childcare expenses? Yes  No   
If yes, include the providers' name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_
7. **For household members aged 62+ or if the head, spouse, or co-head is disabled:**  
Do you pay any out-of-pocket medical expenses not covered by insurance? Yes  No   
If yes, please provide the name of the provider and the total amount paid: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

I/We, the undersigned, certify under penalty of perjury that the information provided here is true and correct, to the best of my knowledge and recollection. Anyone who knowingly submits a false claim or knowingly makes a false statement is subject to criminal and/or civil penalties, including confinement for up to five years, fines, and civil and administrative penalties (18 U.S.C. 287, 1001, 1010, 1012; 31 U.S.C. 3279, 3802).

\_\_\_\_\_  
Signature of Head of Household                      Date

\_\_\_\_\_  
Signature of Other Adult                                      Date

\_\_\_\_\_  
Signature of Spouse or Co-Head                      Date

\_\_\_\_\_  
Signature of Other Adult                                      Date

Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

**WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES 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/TENANT CERTIFICATION**

**Giving True and Complete Information**

I certify that all the information provided regarding household composition, income, family assets, and items for allowances and deductions is accurate and complete to the best of my knowledge.

**Reporting Changes in Income or Household Composition**

I understand that I am required immediately to report, in writing, any changes in income or household size, including when a person moves in or out of the unit. I also understand the rules regarding guests/visitors and when I must report anyone staying with me.

**Reporting on Prior Housing Assistance**

I certify that I have disclosed where I received previous Federal housing assistance and whether any money is owed. I further certify that for this previous assistance, I did not commit fraud, knowingly misrepresent any information, or vacate the unit in violation of the lease.

**No Duplicate Residence or Assistance**

I certify that the house or apartment will be my principal residence and that I will not obtain duplicate Federal housing assistance while participating in this current program. I will notify the Housing Commission immediately in writing if I live anywhere else. I will not sublease my assisted residence.

**Cooperation**

I understand that I am required to cooperate in supplying all information needed to determine my eligibility, level of benefits, or verify my true circumstances. Cooperation includes attending pre-scheduled meetings and completing and signing necessary forms. I understand that failure or refusal to do so may result in delays, termination of assistance, or eviction.

**Criminal and Administrative Actions for False Information**

I understand that knowingly providing false, incomplete, or inaccurate information is punishable under Federal or State criminal law. I understand that knowingly providing false, incomplete, or inaccurate information is grounds for termination of housing assistance or termination of tenancy.

**Signature Of Household Adults**

**Date**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_





608 Pine Street / P.O. Box 928 • Sault Ste. Marie, Michigan 49783  
PHONE 906/635-5841 • FAX 906/635-9500 • TDD No. 1-800-545-1833 Ext. 429 • [www.saulthousing.com](http://www.saulthousing.com)

**AUTHORIZATION TO RELEASE PERSONAL INFORMATION**

I hereby authorize the Sault Ste. Marie Housing Commission to conduct an investigation into my background for the sole purpose of determining my suitability for obtaining or retaining a Public Housing or a Section 8 Voucher. This includes reviewing my criminal history, credit history, rental history, current and prior employment, educational background, disability status, and any other relevant information in accordance with Michigan and federal law.

I request that any custodians of the aforementioned information, including law enforcement agencies, judicial officers, the Department of Health and Human Services (DHHS), medical providers, or any other appropriate persons provide the Sault Ste. Marie Housing Commission with any information pertaining to me.

I authorize the release of all such records and confidential information to any member of the Sault Ste. Marie Housing Commission to be used in conjunction with my application for Public Housing or a Section 8 Voucher, or for my continued participation in these programs.

This authorization shall expire 15 months from the date signed. A photocopy of this authorization shall serve as an original.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

