REDUCTION IN FAMILY SIZE

On _____, you reported that a family member has moved out of your residence.

PLEASE COMPLETE THE QUESTIONS BELOW:

1. Name of family member who moved. _____
2. What date did this person move? _____
3. Where did they move to? Address _____

   _____
4. Will they be gone: [ ] Temporarily [ ] Permanently

   If Temporarily absent, when will they return to your household? _____
5. List below the persons remaining your household:

   _____ _____

   _____ _____

   _____ _____

I certify that the information contained herein is true and correct.

Signature: _____ Date: _____

Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States is guilty of a felony.

TENANT: _____

APPLICANT #: _____

VERIFICATION OF CHILD CARE OR ATTENDANT CARE COSTS

I _____, who reside at

_____ (Street Address)

City _____ State _____ Zip Code _____

Telephone number _____ Social Security Number _____

Do hereby certify that I provide care on the following days for the hours indicated for the following children or dependent persons.

Name	Age	Circle Days Cared For	Hours From		To	
_____	_____	M T W Th F S Su	_____	AM/PM	_____	AM/PM
_____	_____	M T W Th F S Su	_____		_____	
_____	_____	M T W Th F S Su	_____		_____	
_____	_____	M T W Th F S Su	_____		_____	
_____	_____	M T W Th F S Su	_____		_____	

Total hours _____[per week] _____[per month]

Cost of care to the family $_____ [ ] per week [ ] per month

Amount paid by the family $_____ [ ] per week [ ] per month

Estimated cost of care for the upcoming 12 months: $_____
(include full-time summer care of school children, if applicable)

Signed this _____ day of _____, _____

_____ _____

Signature of Care Provider Relationship to parent (if any)

IMPORTANT – This form must be executed whenever a deduction from income is made

WARNING! Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States is guilty of a felony. Also, amounts received from providing childcare and attendant care are reportable to the Internal Revenue Service (IRS).

Are any of the above verified child care costs paid by an agency or individual outside the household? Yes or No (circle)

If yes, provide the Agency/Individual's Name_____ Amount_____

I certify the child care costs information verified above is correct.

_____ _____

Applicant/Resident Date

South Carolina Regional Housing Authority No. 1

460 Church Street
PO Box 326
Laurens, SC 29360

Telephone: (864) 984-0578 Fax: (864) 984-2669

VOLUNTARY CASH CONTRIBUTION

Section 8 Housing Assistance Program

Date: _____

Applicant/Resident: _____

Contract#: _____

This is to certify that I receive $_____ weekly / biweekly / bimonthly / monthly
[Circle One]

From _____ friend / relative / other
[Circle One]

Who resides at _____

_____

This money is used for the upkeep of me and/or family.

_____
Section 8 Applicant/Resident

_____
Witness

South Carolina Regional Housing Authority No. 1

460 Church Street
PO Box 326
Laurens, SC 29360

Telephone: (864) 984-0578 Fax: (864) 984-2669

VOLUNTARY CASH CONTRIBUTION

Section 8 Housing Assistance Program

Date: _____

Applicant/Resident: _____

Contract#: _____

This is to certify that I do not receive a contribution from _____.

The date (month) that I last received a contribution for the upkeep of me and/or family was _____.

I will notify Section 8 in writing if this contribution is received in the future.

_____
Section 8 Applicant/Resident

INCOME VERIFICATION

Company/Agency Name _____

Address _____

_____

The below named person has applied to receive/continue receiving housing assistance through the US Housing Act of 1937 (as amended). The act authorizes the gathering of information to verify a recipient's income. Your cooperation in providing the information requested will be appreciated. COMPUTER PRINTOUTS ACCEPTED.

Section 8 Occupancy Department

I hereby authorize the release of the information requested herein to the SC Regional Housing Authority No. 1

Signed: _____ Social Security #: _____

PLEASE COMPLETE SECTION THAT APPLIES TO YOUR AGENCY

Name/address of employer: _____

Date employed: _____/_____/_____ Date Terminated: _____/_____/_____
Other: _____

Present rate of pay $_____ per_____ effective _____/_____/_____

Employee averages _____ hours per week Average hours overtime weekly _____

Gross earnings past 12 months $_____ Tips past 12 months $_____

SEND THE FOLLOWING PAGES INSTEAD OF COMPLETING THE BELOW INFORMATION

Unemployment [ ] Yes [ ] No Monthly Amount $_____ Date Started_____ Stopped_____

Child Support [ ] Yes [ ] No Monthly Amount $_____ Clerk of Court_____ Direct _____

Income/other sources [ ] Yes [ ] No Monthly Amount $_____

Name of Clerk of Court _____

Name of Payor_____ Court Order/file # _____

Amount paid $_____ Frequency [ ] Weekly [ ] Bi-weekly [ ] Monthly

Verification of pensions/disability insurance payments must include gross amount of benefit/frequency it is received, and any medical deductions that are deducted.

Name/ID _____ File/ID # _____

Name of Agency _____ Phone _____

Signature/Title _____ Date _____

Section 8 Housing Allowances for Tenant Furnished Utilities & Other Services