CHRISTIAN COUNTY/HOPKINSVILLE DEVELOPMENT CORPORATION
CITY OF HOPKINSVILLE
COMMUNITY AND DEVELOPMENT SERVICES
HOPKINSVILLE AFFORDABLE HOMEOWNERSHIP PROGRAM
710 SOUTH MAIN STREET
P.O. BOX 1125
HOPKINSVILLE, KY 42241

APPLICATION

All information will be confidential. Return application to the above-referenced address within 10 days.

Borrower: _____ SS#: _____ Age: _____

Co-Borrower: _____ SS#: _____ Age: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated

Persons living in household besides above:

Name _____ SS# _____ Age _____

Name _____ SS# _____ Age _____

Name _____ SS# _____ Age _____

Name _____ SS# _____ Age _____

Name _____ SS# _____ Age _____

Please list all wage earners and income in household 18 years or older except all full time students residing in household. Please include all income (i.e., Employer, Social Security, SSI, Welfare, Child Support, Alimony, Disability, Pension).

Name	Name of Employer or Other	# of Years Employed	Annual Gross Salary

Total family gross annual income received from all sources: $_____

Have you ever owned property (i.e., home/mobile home)?

_____ Yes _____ No

If yes, date sold _____

Are your assets over $5,000? _____ Yes _____ No

Amount of funds available for deposit and downpayment on purchase of house? $_____

Exact source of downpayment (i.e., bank, gift) If from someone other than yourself, please indicate below the name, address, and phone number of individual giving you the downpayment as a loan or gift.

_____

Name Address Phone #

TO THE BEST OF MY/OUR KNOWLEDGE, THE INFORMATION SUPPLIED TO YOU FOR THE COMPLETION OF THIS FORM IS TRUE AND ACCURATE. ANY FALSE STATEMENTS MADE KNOWINGLY AND WILLFULLY MAY SUBJECT THE SIGNER(S) PENALTIES UNDER SECTION 1001 AND 1010 OF TITLE 18 OF THE UNITED STATES CODE.

_____ _____

Borrower Date Co-Borrower Date

EQUAL HOUSING OPPORTUNITY

V. APPLICANT AUTHORIZATION AND CERTIFICATION

I certify that the statements made by me in this application are true, complete and correct to the best of my knowledge and belief, and are made in good faith to obtain rehabilitation assistance.
I understand that any information, including income, provided in this application may be given to other State or Local Agencies in order to coordinate rehabilitation and financial assistance.

WARNING: Section 1001 of Title 18, United States Code provides: "Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up a materials fact, or makes any or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five (5) years, or both."

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of any information needed by Community and Development Services Hopkinsville, Kentucky in order to determine relocation benefits and/or eligibility for Federal Housing Rehabilitation assistance.
It is specifically agreed that this information will be utilized only for the determination of relocation benefits and/or housing rehabilitation assistance and will not be divulged to any unauthorized individuals.

Signature of Applicant _____ Signature of Co-Applicant _____

SSN _____ SSN _____

Date _____ Date _____

PHOTO RELEASE

I hereby give the Christian County/Hopkinsville Development Corporation and the Community and Development Services permission to utilize video and photographic images of myself and/or my above listed property (before and after project images) for the sole purpose of advertising the Hopkinsville Home Improvement Program. I also understand that I will not receive any compensation for the use of said images.

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of any information needed by the Community Services Division of Community Development Services in order to determine relocation benefits and/or eligibility for Federal Housing rehabilitation assistance.

It is specifically agreed that this information will be utilized only for the determination of relocation benefits and /or housing rehabilitation assistance and will not be divulged to any unauthorized individuals.

Applicant's Name	Co-Applicant's Name
Applicant's Social Security #	Co-Applicant's Social Security #
Veteran's Administration # (if applicable)	Co-Applicant's VA # (if applicable)
Date	Date
Witness	Date

KENTUCKY HOUSING CORPORATION
PERSONAL DECLARATION
THIS FORM MUST BE COMPLETED IN FULL AND SIGNED BY ALL ADULTS

Please complete this form **in your own handwriting**. Use the correct legal name for each member of your household as it appears on their Social Security card. All adult members of the household must sign below to certify the information pertaining to them. **For this program, the Head of Household simply refers to the person whose name the assistance is in.** Thank you for your cooperation.

PLEASE PRINT AND COMPLETE THIS FORM IN INK

1. **HOUSEHOLD COMPOSITION:** Complete for all persons who will be living in your home listing head of household first. Please provide your telephone number or a telephone number where a message may be left. **Telephone No.:** _____

Home Address (where you live now) _____ City _____ Zip _____
Mailing Address _____ City _____ Zip _____

Please provide an alternate contact person in case we are unable to contact you in a timely manner. Name of alternate contact person is: _____, Address: _____, Telephone: _____

*Race: White, Black, American Indian/Alaskan Native, Asian or Pacific Islander, Hispanic, Other

Adults (Legal Name) Last First	Sex (M/F)	Date of Birth	Age	Social Security Number	Relation to Head	Place of Birth (City/State)	*Race
					HEAD		

Children (Name as it appears on SS card)	Sex (M/F)	Date of Birth	Age	Relation to Head	Social Security Number	Place of Birth (City/State)	Name/Address of Father/Mother Not Living With Children	*Race

You are not required to answer whether a family member has a disability; however, it may lower your rent portion. Is anyone in your household elderly, or a person with a disability? ☐ Yes ☐ No If yes, list name(s): _____
Is there any specific accommodation you would like to request which would allow you to fully utilize our programs? ☐ Yes ☐ No
If yes, please explain: _____
If yes, do you have any outstanding medical bills? ☐ Yes ☐ No
Is anyone in your household (18 or older) a full-time student? ☐ Yes ☐ No If yes, list name(s) _____

2. **TOTAL HOUSEHOLD INCOME:** Please list below all money earned or received by everyone living in your household.

Name of Household Member Receiving Income	Name/Address of Employer or Self-Employment Information	Gross Weekly Wages or Self-Employment Income	Monthly K-TAP Amount	Monthly Child Support	Monthly Social Security or SSI Benefits or Pensions	Weekly Unemployment Benefits

Do you have any other income not listed above? ☐ Yes ☐ No If yes, list amount and type: _____
Do you or anyone in your household have a checking and/or savings account? ☐ Yes ☐ No If yes, list: _____
Do you pay child care expenses? ☐ Yes ☐ No How much per month? _____ Are you reimbursed? ☐ Yes ☐ No
Does anyone help you pay your bills? ☐ Yes ☐ No If yes, list: _____
Is the head of household or spouse a member of the Armed Services? ☐ Yes ☐ No
If yes, list the name of the person and monthly income: _____

3. ASSETS:

Do any family members have or receive income from: (check if applies)

☐ Real Estate ☐ Company Retirement/Pension Funds ☐ Insurance Settlements
☐ Stocks ☐ Trusts ☐ Other Assets: _____
☐ Certificate of Deposit ☐ Bonds _____

Have you disposed of any assets during the past two years for less than fair market value? ☐Yes ☐No
If yes, explain: _____

4. GENERAL INFORMATION:

1. Have you or any other adult members ever used any name(s) or Social Security number(s) other than the ones currently being used?
   ☐Yes ☐No If yes, list name and Social Security number(s) and which member:
   _____
2. Do you currently owe money or any type of claim to any Housing Authority? ☐ Yes ☐ No If yes, explain: _____
   _____
3. Have you or anyone in your household been convicted, arrested, charged or evicted from federally assisted housing, including public housing, for any violent, criminal activity in the last three years? ☐ Yes ☐ No If yes, give names, dates and details of incidents for each occurrence:
   _____
   _____
4. Have you or anyone in your household been evicted from federally assisted housing, including public housing, for abuse of alcohol which interfered with the health, safety or right to peaceful enjoyment of the premises by other residents in the last three years? ☐ Yes ☐ No
   If yes, give names, dates and details of incidents for each occurrence: _____
   _____
5. Have you or anyone in your household been convicted, arrested, charged or evicted from federally assisted housing for drug-related criminal activity in the last three years? ☐ Yes ☐ No If yes, give details: _____
   _____
6. Current monthly household expenses: Please list approximate amounts you pay monthly for each of the following. List "NONE" if you pay nothing.

Auto $	Child Care $	Telephone $	Credit Cards (list)
Furniture $	Medical $	Insurance $	$
Cable $	Loans $	Other $	$

Please have all family members age 18 and over review the information listed on this form and sign below.

I do hereby swear and attest that all of the information above is true and correct. I understand that any change in source of income, new or additional sources of income and changes in household members must be reported within 14 days of such change. Reporting requires that you provide verification of information to the housing agency staff. Thank you.

PLEASE BE SURE YOU HAVE ANSWERED ALL QUESTIONS
Otherwise we will be unable to process your information.

_____ _____
Signature of Head of Household Date Signature of Spouse Date
(the name of person receiving assistance)

_____ _____
Signature of Other Household Adult Date Signature of Other Household Adult Date

Additional space to use if needed: _____

_____

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. Kentucky Revised Statute 514.040, Theft by Deception, makes it a crime to knowingly give false information to get into housing, to get a lower rent, or to receive aid and/or benefits under any state or federally funded assistance program.***

CERTIFICATION OF ZERO INCOME

I hereby certify there is no income/money received by (check as appropriate):

- ☐ Me; and/or
- ☐ Any member of my household

from any source including, but not limited to, income from wages, public assistance, Social Security, pensions, benefits, child support and/or alimony.

_____
Signature

_____
Print Name

_____
Date

_____
Address

_____
Telephone Number

WARNING: *Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any department or agency of the U.S. as to any matter within its jurisdiction.*

Exhibit 4.4(q)

DISPOSED OF ASSETS VERIFICATION

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Date _____

1. Has any member of your household sold or otherwise disposed of any asset during the past two (2) years?
   ☐ Yes ☐ No

2. If no, do not complete this form.
   If yes, was this asset disposed of due to foreclosure, bankruptcy, divorce or separation settlement?
   ☐ Yes ☐ No

3. If the answer to No.2 is yes, do not complete this form.
   If the answer to No.1 is yes, and the answer to No.2 is no, please continue:

   a. Describe the asset:

   b. The fair market value of this asset was: $_____
   (attach copy of most recent tax bill and/or real estate comparability study)

   c. The fair market value of this asset was determined by:_____

   d. This asset was sold or disposed of for: $_____

   e. The documentation providing proof of the amount of sale is:_____
   (attach support documentation)

****

For office use only:

Calculation of disposed asset:

A. Enter the amount of line 3b here: $_____
B. Enter the amount of line 3d here: $_____
"-"
C. Total disposed asset "=" $_____ "x" _____ "=" _____
(Current HUD passbook rate)

Total of line C equals the total income from the asset disposed of for less than fair market value.

Signature _____ Title _____ Date _____

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SWORN STATEMENT OF ASSETS

This form may be used by HOME recipients to verify the value of all household assets and income derived from these assets. **Note:** All assets must be verified regardless of cash value.

ASSETS INCLUDE

- Average six month balance in checking accounts
- Amounts in savings account.
- Stocks, bonds, savings certificates, money market funds and other investment accounts.
- Equity in real property or other capital investments (for example, rental property that you own).
- The cash value of trusts that are available to the household.
- Contributions to company retirement/pension funds that can be withdrawn without retiring or terminating employment.

IRA, Keogh and similar retirement savings accounts, even though withdrawal would result in a penalty.

Assets which, although owned by more than one person, allow unrestricted access by the applicant.

Lump sum recipients such as inheritances capital gains, lottery winnings, insurance settlements and other claims.

Personal property held as an investment such as gems, jewelry, coin collections, antique cars, etc.

Assets disposed of for less than fair market value during two years preceding certification or recertification.

For the next 12 months, the income (for example, interest, dividends, etc.) from our assets is expected to be $_____.

I have carefully read this statement and I swear or affirm that it is true to the best of my knowledge, information and belief.

Signature of Client Date	Signature of Client Date
Printed Name	Printed Name
Sworn to me and subscribed in my presence this ____day of _____,_____.	Sworn to before me and subscribed in my presence this ____day of _____,_____.
Signature of Notary Public	Signature of Notary Public
My commission expires:_____	My commission expires:_____

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EMPLOYMENT VERIFICATION

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY CLIENT

TO: (Name & address of employer) Date: _____

_____

_____

_____

RE: _____ _____
Applicant/Tenant Name Social Security Number

I hereby authorize release of my employment 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.

Return Form To: (Name & address of agent)

_____
Project Owner/Management Agent

LeeAnn Sorrell
P.O. Box 1125
Hopkinsville, KY 42241-1125

THIS SECTION TO BE COMPLETED BY EMPLOYER

Employee Name: _____ Job Title: _____

Currently Employed: Yes ☐ Date First Employed _____ No ☐ Last Day of Employment _____

Current Wages/Salary: $_____ (check one) ☐ hourly ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly ☐ yearly ☐ other _____

Average # of regular hours per week: _ Year-to-date earnings: $_____ through ___/___/___

Overtime Rate: $_____ per hour Average # of overtime hours per week: _____

Shift Differential Rate: $_____ per hour Average # of shift differential hours per week: _____

Commissions, bonuses, tips, other: $_____ (check one) ☐ hourly ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly ☐ yearly ☐ other _____

List any anticipated change in the employee's rate of pay within the next 12 months: _____ Effective date: _____

If the employee's work is seasonal or sporadic, please indicate the layoff period(s): _____

Additional remarks: _____

_____ _____ _____
Employer's Signature Employer's Printed Name Date

_____ _____ _____
Phone # Fax # E-mail

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BANKING VERIFICATION

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

To Whom It May Concern:

The person referenced above is a participant in our HOME Investment Partnerships (HOME) and/or Affordable Housing Trust Fund (AHTF) programs. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Participant's Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY BANKING INSTITUTION

	Last 6 months Average Balance	Last 6 months Interest Income	Date Account Opened
Checking Account:			
_____	$_____	$_____	_____
_____	$_____	$_____	_____
Savings Account:			
_____	$_____	$_____	_____
_____	$_____	$_____	_____
Other Accounts (list):			
_____	$_____	$_____	_____
_____	$_____	$_____	_____

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Financial Institution _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VERIFICATION OF SOCIAL SECURITY

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

Benefit Amount:

Gross Social Security benefit (monthly) $_____

Gross Supplemental Security Income\ Disability (monthly) $_____

Amount deducted for Medicare $_____

Date benefits began: _____ Date ended: _____

Type of Benefit (check if applicable):

☐ Retirement

☐ Participant

☐ Widow(er)

☐ Children

Status of Application (check one):

☐ Claim is pending ☐ No record ☐ Other

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VERIFICATION OF DISABILITY

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the disability of program participants if they so request. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

HUD Definition of Disabled Persons

A person is considered disabled if the Social Security disability definition is met as described in paragraph (1), or the individual has a developmental disability as described in paragraph (2). Please check as appropriate:

☐ (1) Section 223 of the Social Security Act defines disability as:

"Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, or

"In the case of an individual who attained the age of 55 and is blind and unable by reason of such blindness to engage in substantial, gainful activity requiring skills or ability comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time."

☐ (2) Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. 6001(7)] defines developmental disability in functional terms as:

"Severe chronic disability that:

a. is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. is manifested before the person attains age 22;
c. is likely to continue indefinitely;
d. results in substantial functional limitations in three or more of the following areas of major life activity:
    1. self-care,
    2. receptive and responsive language,
    3. learning,
    4. mobility,

5. self-direction,
6. capacity for independent living and
7. economic self-sufficiency;

e. reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated."

(3) This participant does not meet HUD's definition of disabled.

I certify that this information is accurate.

Signature of Physician _____ Name of Physician (print) _____

Medical Office _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Date _____

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VERIFICATION OF CHILD SUPPORT

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The applicant/resident must complete the information below and provide the requested documentation.

Applicant/Resident receives child support: ☐ **Yes (Please provide documentation)** ☐ **No (No further action required)**

If yes,

Amount of child support awarded: $_____ per week

If inconsistent, list total received in last six months: $_____

(Please provide documentation of payment inconsistency)

Date child support payments began: _____ Date ended: _____

Name(s) of children for which support payments are made:

_____ _____

_____ _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Relationship to Client _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VERIFICATION OF PUBLIC ASSISTANCE

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

Benefits:		**Date Began**	**Date Ended**
Amount of assistance received monthly:	$_____	_____	_____
Amount of child support received monthly:	$_____	_____	_____
Other income in household (list):_____	$_____	_____	_____

Names of household members:

_____ _____

_____ _____

_____ _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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KENTUCKY HOUSING CORPORATION
VERIFICATION OF PUBLIC ASSISTANCE and JOB TRAINING ASSISTANCE

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The above-mentioned person is a participant in a federally-assisted housing program. We are required by federal regulations to verify the income of program participants and their household members. Please complete all of the information below. We do not include food stamps as income, but we must have food stamp, medical card and Jobs Training, or similar program, information to process and track Family Self-Sufficiency Program participants. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

Benefits Received	Amount	Date Began	Date Ended	YTD Amount
K-TAP benefits received monthly:				
Food stamps received monthly:				
Child support income received monthly:				

Medical card ☐ YES ☐ NO

Training and Other Income

Work Experience/Jobs Training/or similar program ☐ YES ☐ NO

Name of Program: _____

Date training employment began _____ ended (or will end) _____

If in Jobs Training Program, amount of original K-TAP benefits family qualified to receive (disregarding wage income)

$_____ Other income in household ☐ YES ☐ NO

Please list other income amounts and those receiving: _____

Please list all household members: _____ _____

_____ _____ _____

_____ _____ _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

PLEASE RETURN TO: _____

_____

_____

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VERIFICATION OF INFORMAL SUPPORT

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

I certify that I provide assistance in the amount of $_____each month.

The assistance provided is for _____.

Please list other assistance provided: _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Relationship to Client _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VERIFICATION OF STUDENT STATUS

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

The participant referenced above is a student at this institution and is enrolled:

☐ Full-time ☐ Part-time ☐ Not enrolled

Expected date of completion: _____

Approximate number of hours in school: _____

Address of student: _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VERIFICATION OF SECTION 8 INCOME

TO WHOM IT MAY CONCERN:

The client listed below has indicated that he/she is receiving Section 8 housing assistance from your agency. Information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy in a project funded by the HOME Investment Partnerships (HOME) Program.

Sincerely,

_____
Project Owner/Manager

I/We need this information to certify that this (client/tenant) household is in compliance with HOME eligibility requirements.

****

I hereby authorize the above management agent to make inquiries regarding my income for the purpose of determining my eligibility for occupancy.

Signed: _____ Date: _____

Client: _____ SSN: _____

Address: _____

_____

Date of Move-In: _____ Date of Recert: _____

Family Size:_____

****

This is to certify that _____ (client/tenant) who is a recipient of a Section 8 Certificate/Voucher from this PHA has GROSS annual income of $_____ _____, as of _____(date) for year _____.

Signature of PHA Worker: _____Date: _____

Name of PHA: _____Telephone No.:_____

VERIFICATION OF MILITARY INCOME

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

Income

Amount of **Monthly** Income to Participant: $_____

OR

Amount of **Weekly** Income to Participant: $_____

Date Service Began: _____ Date Service Ended: _____

Please exclude amounts for exposure to hostile fire.

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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VETERANS ADMINISTRATION BENEFITS/DISABILITY BENEFITS/ WORKERS' COMPENSATION/UNEMPLOYMENT COMPENSATION

Client _____ SSN _____

Address _____ City _____ State _____ Zip _____

The person referenced above is a participant in a project funded by the HOME Investment Partnerships Program. The U.S. Department of Housing and Urban Development (HUD) requires that we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the release of this information.

Signature of Client _____ Date _____

Benefit Amount

Amount of **Monthly** Payments to Participant: $_____

OR

Amount of **Weekly** Payments to Participant: $_____

Date Payments Began: _____ Ending Date of Payments: _____

Type of Benefit (check one):

- ☐ Workers' Compensation
- ☐ Unemployment Compensation
- ☐ Disability Benefits
- ☐ VA Benefits
- ☐ Other (please list): _____

I certify that this information is accurate.

Signature _____ Name (print) _____

Title _____ Date _____

Agency _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

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AFFIDAVIT IN VERIFICATION OF SELF-EMPLOYMENT

This affiant(s) (Name)_____ of (Address)_____

being first duly sworn deposes and says that _____ is self-employed, said occupation being _____.

The affiants' place of business is located at: _____.

I sign the declaration under penalty of perjury and with full knowledge of the repercussions of willful falsification and false swearing under Kentucky law.

STATEMENT OF INCOME FROM BUSINESS

Instructions:

1. Opposite GROSS INCOME insert total amount earned during the past 12 months or shorter period.
2. Add all expenses incurred in the performance of this business and subtract the total of these EXPENSES from the gross income.
3. Insert the result in the space NET INCOME.

A. GROSS INCOME: $_____ period covered by GROSS income shown.
Beginning date: _____ Ending date: _____

B. EXPENSES:

1.	Cost of goods and materials	$_____
2.	Rent (business location only)	$_____
3.	Heat, light, water, phone, etc. (business only)	$_____
4.	License fees	$_____
5.	Other (specify)	$_____
6.	Number of Employees _____	
7.	Employees' salaries (other than self/family)	$_____
8.	Owner's salary (self/family)	$_____

C.
GROSS INCOME $_____
TOTAL EXPENSES "-" $_____
NET INCOME: "=" $_____

D. Total amount of income taxes paid as of _____

Federal Taxes		$_____
State Taxes	"+"	$_____
City Taxes	"+"	$_____
TOTAL TAXES: "="		$_____

ATTACH MOST RECENT COPY OF YOUR FEDERAL TAX RETURN.

The above information is correct to the best of my knowledge, and I agree to notify _____ annually of any changes.

Signature: _____ Date: _____
In witness whereof, this _____ day of _____.
My commission expires: _____

_____
(Notary Public)

PENSION/RETIREMENT/ANNUITY INCOME

Applicant/Resident: _____ Social Security No.: _____
Unit No.: _____

To Whom It May Concern:

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.

By signing below I authorize the release of this information.

_____ _____
Participant's Signature Date

THIS SECTION TO BE COMPLETED BY PROVIDING AGENCY

Benefit Amount

Amount of **Monthly** Payments to Participant: $_____
OR
Amount of **Weekly** Payments to Participant: $_____
Date Payments Began: _____ Date Payments Ended: _____
Deductions from Gross Income for Medical Insurance Premiums: $_____

Type of Benefit (check one):
O Pension O Annuity O Retirement
O Other (please list): _____

I certify that this information is accurate.

_____ _____
Signature Name (print)

_____ _____
Title Date

_____ _____
Agency/Company Telephone Number

_____
Address City State Zip

WARNING: **Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any department or agency of the U.S. or to any matter within its jurisdiction.**

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