

JAMES MARATHAS  
Executive Director  
TDD 1-800-545-1833 ext 115  
Telephone: (617) 847-4350  
Fax: (617) 479-3105

# QUINCY HOUSING AUTHORITY

80 CLAY STREET QUINCY, MASSACHUSETTS 02170-2799



July 1, 2020

## IMPORTANT RENEWAL NOTICE

«First\_Name» «Last\_Name»  
«Mail\_Street\_Num» «Mail\_Street1», «Mail\_Apt\_Num»  
«Mail\_Street2»  
«Mail\_City», «Mail\_State» «Mail\_Zip»

Dear Tenant Leased Housing Participant:

It is time for your household's Annual Review for continued eligibility with the *Section 8 Program*. Your renewal month is **NOVEMBER 2020** and your new rent will go into effect at that time. **You will receive a Notice of Rent Change by mail in advance of your renewal date providing all verification requirements are met in a timely manner.**

**Please use the checklist below prior to submitting your household's documents:**

- Continued Occupancy Form** (Please include information for ALL household members)
- Verification of Employment Income:** Please submit your most recent consecutive paystubs; Biweekly pay cycle (2) and/or Weekly pay cycle (4).
- Public Assistance/Welfare/TANF:** Verification letter stating benefit amount. Information may be obtained by calling **877-382-2363**, online by signing up for My Account Page at [www.mass.gov/vg/selfservice](http://www.mass.gov/vg/selfservice) or by visiting your local DTA office.
- Unemployment/Workmen's Compensation:** Provide a copy of your most current benefit letter. You may call **1-617-626-6600** to obtain this information.
- Pension Verification-** You may submit your most recent statement or the *Pension Verification Form*
- SSI/SSP State (for elderly or disabled participants):** Provide letter/verification of monthly income. You can request a letter by calling the SSP Client Assistance Line at **1-877-863-1128**.
- Claiming Zero Income-** Age 18 and over, not a full-time student, must request and submit a Zero Income Packet
- Full-Time Student-** 18 and over, submit school letter verifying enrollment status & expected date of graduation
- Assets:** Provide 3 of your most recent consecutive bank statements for all bank accounts (checking and/or savings accounts, CD's, etc.) You may also submit the **Bank Verification Form**
- Child Support/Alimony Payments:** You may contact Child Support Enforcement Division for a 12 month print out, or log onto your online account. If you receive child support directly from the non-custodial parent, you must obtain a notarized statement from the non-custodial parent that includes the name, address and phone number as well as amount and frequency of payments.
- Child Care Expenses:** Provide verification/receipt of payment of unreimbursed child care expenses for the last 12-month period. You may also provide the **Child Care Verification Form**
- Medical Expenses (for elderly or disabled participants):** Provide verification of payment/receipts of any out of pocket medical expenses such as; medical bills, medicare part D, pharmacy printouts, and insurance premiums/co-pays for the specified 12-month period.
- Utilities-**A copy of all of your most recent utility bills.
- General Authorization for the Release Information (Signed by all household members age 18 and over)**
- Authorization for the Release of Information/Privacy Act Notice (Signed by all household members age 18 and over)**
- Applicant/Tenant Statement/Certification (Signed by all household members age 18 and over)**
- Grounds for Termination and/or Family Responsibilities (Signed by all household members age 18 and over)**

Submit all documentation to the attention of the **Leased Housing Department NO LATER THAN JULY 15, 2020** by MAIL or by DROPPING OFF WITH OUR RECEPTIONIST in a sealed envelope. **Be sure to make copies of anything needed for your records as we WILL NOT return paperwork.** If you submit any paperwork by fax, be sure to send the **front and back of relevant forms**. You may be requested to forward hardcopies if faxed paperwork is not clear and readable.

**Be advised that unit Inspections are conducted by the Quincy Housing approximately every two years. You will be given advanced notice by mail regarding any required inspections.**

**FAILURE TO COMPLY** with these *Family Obligations* as set forth in *HUD Regulations* will be **Grounds for Termination** of your Housing Assistance. **THIS WILL BE ENFORCED.** If you plan to move or no longer wish to participate in the *Section 8 Program*, you **must** notify this office as soon as possible.

Sincerely,  
Leased Housing Department

«Annual\_Month» «Staff\_Assigned»

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## CONTINUED OCCUPANCY FORM

«Annual\_Month» «Staff\_Assigned»

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

**Emergency Contact**

NAME: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**FAMILY COMPOSITION:**

LIST ALL HOUSEHOLD MEMBERS, INCLUDE YOUR INFORMATION IN ROW ONE. (ATTACH ADDITIONAL SHEET IF NECESSARY)

#	NAME	BIRTH DATE	PLACE OF BIRTH	SOCIAL SECURITY #	RELATION TO HEAD	SEX	MARITAL STATUS	CITIZEN OF US?
1					HEAD			Yes / No
2								Yes / No
3								Yes / No
4								Yes / No
5								Yes / No
6								Yes / No

HAVE YOU HAD A CHANGE IN INCOME OR FAMILY COMPOSITION?  YES  NO

DO YOU ANTICIPATE A CHANGE IN INCOME OR FAMILY COMPOSITION?  YES  NO

IS THERE A FAMILY MEMBER BETWEEN THE AGES OF 18-25 THAT IS A FULL-TIME STUDENT?  YES  NO

**INCOME:** LIST ALL MEMBERS NOW WORKING EITHER FULL OR PART-TIME, WHICH INCLUDES ALL EARNED INCOME. (ATTACH ADDITIONAL SHEET IF NECESSARY) **IMPORTANT NOTE:** HOUSEHOLD MEMBERS AGE 18 AND OVER WHO STATE THEY HAVE NO INCOME MUST COMPLETE AND SUBMIT A ZERO INCOME PACKET ALONG WITH VERIFICATION OF NO INCOME FROM THE I.R.S.

Family Member	Employer Name	Employer Address	Employer Telephone	Wages

**OTHER INCOME:** PLEASE LIST INCOME RECEIVED FROM ANY AND ALL SOURCES FOR EACH HOUSEHOLD MEMBER, INCLUDING CHILDREN. (ATTACH ADDITIONAL SHEET IF NECESSARY)

Social Security \$	Pension \$	Self-Employment \$
SSI \$	Survivors Ins. \$	Child Support \$
SSP \$	Unemployment \$	Alimony \$
Veterans Benefits \$	EAEDC Cash Benefits \$	Annuity \$
Disability Pay \$	TANF-Cash Benefits \$	Dividends \$

**ASSETS:** DO YOU HAVE ASSETS, SUCH AS BUT NOT LIMITED TO: (CIRCLE ALL THAT APPLY)

CHECKING ACCT   IRA'S   SAVINGS ACCT   MONEY MARKET FUNDS   CD'S   ANNUITIES  
 BONDS   STOCKS   MUTUAL FUNDS   REAL ESTATE   RENTAL PROPERTY   LAND

Do you have a limited ability to speak, read, write, or understand English? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes, please state your primary language \_\_\_\_\_

(Please see attached notice of right to a reasonable accommodation)

The above Statements are made under the penalty of perjury. I authorize Quincy Housing Authority to inquire and obtain information about me and my family that is pertinent.

X \_\_\_\_\_  
**SIGNATURE**

X \_\_\_\_\_  
**DATE**

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## ANNUAL VERIFICATION OF UTILITIES

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

Address: **x** \_\_\_\_\_ Town **x** \_\_\_\_\_

As part of the annual renewal process, you **MUST COMPLETE THIS FORM AND PROVIDE VERIFICATION** for each utility you are responsible for.

Check all of the utilities you are responsible to pay in your current leased unit:

HEAT

Electric \_\_\_\_\_ Oil \_\_\_\_\_ Gas \_\_\_\_\_

HOT WATER

Electric \_\_\_\_\_ Oil \_\_\_\_\_ Gas \_\_\_\_\_

COOKING

Electric \_\_\_\_\_ Oil \_\_\_\_\_ Gas \_\_\_\_\_

LIGHTS

Electric \_\_\_\_\_

REFRIGERATOR: Do you own it? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please submit the following documentation:

- For each utility you are responsible for, submit verification in the form of a copy of your **most recent utility bill** or other appropriate documentation from the utility company to confirm that the utility is active in your unit under your name as head of household.
- If a utility is listed under a name other than the head of household, a notarized statement must be provided as to the relationship of this person and why the utility is listed under this name.

**x** \_\_\_\_\_  
Head of Household Signature Date

«Annual\_Month» «Staff\_Assigned»

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## **NOTICE OF RIGHT TO A REASONABLE ACCOMMODATION**

If you have a disability and as a result of this disability need:

- A change in policy or procedure to accommodate your circumstances
- A change in the way we communicate with you or provide information

You may request this change, which is called a "Reasonable Accommodation". A Reasonable Accommodation means that we will make every effort to make a change or assist you with a request as long as the request does not create "an undue Financial or Administrative burden" (in other words, is too expensive or too difficult to arrange). Please keep in mind with any request that we must remain within the guidelines of the subsidy program.

You will be requested to provide appropriate documentation of your disability to the Housing Authority in order for your Reasonable Accommodation request to be considered. This office will review the information and respond to your request in a reasonable period of time. If your request is denied, we will provide you with the reason(s) for the denial and you will be given the opportunity to request an Informal Review of the decision and to provide additional information if you believe it will assist in reconsidering approval.

If you need assistance completing a Reasonable Accommodation Request Form or would like to make your request in another way, contact your Leasing Officer at 617-847-4350.

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## INCOME VERIFICATION

### SECTION 1. (Leased Housing Participant MUST COMPLETE AND SIGN SECTION 1)

TENANT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. NO.: \_\_\_\_\_

CITY: \_\_\_\_\_ MA \_\_\_\_\_

I hereby authorize the release of this information.

\_\_\_\_\_ Date Tenant Signature  
=====

We are required to verify the income of all members of families living in assisted housing. Please supply the information requested below. We will keep this information in strict confidence and use it only to determine your employee's eligibility for housing at a special rental rate. Your prompt return of this information will be appreciated.

Please return to Quincy Housing Authority, ATTN: Leased Housing Department, 80 Clay St. Quincy, MA 02170 or FAX 617-479-3105

### «Annual Month» «Staff Assigned»

Leased Housing Department: Leasing Officer  
=====

### SECTION 2. (EMPLOYER MUST COMPLETE SECTION 2)

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATE EMPLOYMENT BEGAN: \_\_\_\_\_ If applicable DATE EMPLOYMENT ENDED: \_\_\_\_\_

- GROSS SALARY: \$ \_\_\_\_\_
- Pay Frequency: (CIRCLE ONE)  
WEEKLY BI-WEEKLY SEMI-MONTHLY MONTHLY ANNUALLY
- If employee is paid hourly, please specify rate \_\_\_\_\_ and average number of hours per week \_\_\_\_\_
- OTHER COMPENSATION NOT INCLUDED ABOVE (SPECIFY SOURCE OF THIS INCOME, COMMISSIONS, BONUSES, TIPS, ETC)  
\$ \_\_\_\_\_ FOR \_\_\_\_\_

HEALTH INSURANCE DEDUCTED \$ \_\_\_\_\_ (CIRCLE ONE)  
WEEKLY BI-WEEKLY MONTHLY ANNUAL

IF TERMINATED IS EMPLOYEE ELIGIBLE TO COLLECT UNEMPLOYMENT BENEFITS YES or NO

\_\_\_\_\_  
SIGNATURE OF EMPLOYER

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
CONTACT NUMBER

\_\_\_\_\_  
DATE

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## PENSION AND ANNUITY VERIFICATION

**NOTE:** SECTION 2 OF THIS FORM MUST BE COMPLETED BY THE PENSION PROVIDER. IT IS NOT TO BE FILLED OUT BY THE TENANT. THE TENANT WILL COMPLETE AND SIGN SECTION 1 ONLY.

**IN PLACE OF THIS FORM, A LETTER FROM THE PENSION PROVIDER WILL BE ACCEPTABLE.**

**SECTION 1. TO BE COMPLETED BY Leased Housing Participant**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY NO.: \_\_\_\_\_

I hereby authorize the release of this information.

\_\_\_\_\_  
TENANT SIGNATURE

\_\_\_\_\_  
DATE

**SECTION 2. TO BE COMPLETED BY PENSION PROVIDER**

We are required to verify the income of all members of a family applying for or living in Assisted Housing. We will keep this information in strict confidence and use it only to determine eligibility or rent. Please supply the required information requested below regarding the above referenced individual. Your prompt return of this information is appreciated. Please mail this form to Quincy Housing Authority, 80 Clay St., Quincy, MA 02170 ATTN: Leased Housing Department, or FAX 617-479-3105.

**«Annual Month» «Staff Assigned»**

Leased Housing /HAP SPECIALIST

COMPANY NAME	
ADDRESS	
TELEPHONE	
MONTHLY GROSS AMOUNT OF PENSION/ANNUITY	
DEDUCTIONS FROM GROSS FOR MEDICAL EXPENSES	

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
CONTACT NUMBER

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

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**BANK ACCOUNT VERIFICATION (Assets)**

**SECTION 1. TO BE COMPLETED BY CLIENT AND SUBMITTED TO BANK**

NAME:  \_\_\_\_\_

ADDRESS:  \_\_\_\_\_ APT NO.: \_\_\_\_\_

\_\_\_\_\_

SOCIAL SECURITY NO:  \_\_\_\_\_

I hereby authorize the release of this information.

\_\_\_\_\_  
 TENANT SIGNATURE

\_\_\_\_\_  
 DATE

**SECTION 2. TO BE COMPLETED BY PROVIDER**

We are required to verify the income of all members of a family applying for or living in Assisted Housing. We will keep the information in strict confidence and use it only to determine eligibility or rent. Please supply the required information requested below regarding the above referenced individual. Your prompt return of this information is appreciated. Please mail this form to Quincy Housing Authority, 80 Clay St., Quincy, MA 02170 ATTN: **Leased Housing Department** or **FAX: 617-479-3105**

«Annual Month» «Staff Assigned»  
 LEASED HOUSING /HAP SPECIALIST

NAME OF BANK: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY AND PROVIDE ALL CURRENT INFORMATION

ACCOUNT	CURRENT BALANCE	INTEREST RATE	ACCOUNT NUMBER	DATE CLOSED
Checking Account				
Savings Account				
Money Market				
CD				
IRA				
Other				

\_\_\_\_\_  
 SIGNATURE OF BANK REPRESENTATIVE

\_\_\_\_\_  
 CONTACT NUMBER

\_\_\_\_\_  
 DATE





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**CITIZENS BANK FORM**

**HOUSING VERIFICATION OF ASSETS REQUEST FORM**

This form should only be used by authorized Assisted Housing Authorities to obtain verification of assets on a Citizens Bank customer to determine eligibility for low income government assisted housing.

All fields and customer's authorization are required for response. Housing Authority will Fax form to **866-999-0256** to receive a response within approximately 2 days.

**Citizens Bank Customer's Information (please print)**

**Complete information by each "X" on the form**

Social Security Number	x		
Name on Account	x		
Address on Account	x		
City x		State MA	Zip x
<b>PLEASE CHECK ACCOUNT TYPE</b>		<b>LIST Account Number</b>	
<input type="checkbox"/> Reg. Checking <input type="checkbox"/> Interest Checking <input type="checkbox"/> Savings <input type="checkbox"/> CD <input type="checkbox"/> IRA <input type="checkbox"/> Other _____			
<input type="checkbox"/> Reg. Checking <input type="checkbox"/> Interest Checking <input type="checkbox"/> Savings <input type="checkbox"/> CD <input type="checkbox"/> IRA <input type="checkbox"/> Other _____			
<input type="checkbox"/> Reg. Checking <input type="checkbox"/> Interest Checking <input type="checkbox"/> Savings <input type="checkbox"/> CD <input type="checkbox"/> IRA <input type="checkbox"/> Other _____			

I authorize Citizens Bank to release the balance, average balance, interest rate if applicable and opening date on the account(s) listed above to the requestor for the purpose of determining my eligibility for assisted housing. I understand that if the information I have provided herein is not accurate or complete that my total account relationship may be reported.

X \_\_\_\_\_  
**Signature of account holder**

X \_\_\_\_\_  
**Date**

Requesting Housing Agency Information (please print)  
 All fields below are required for response

Housing Agency: <b>Quincy Housing Authority</b>		«Annual Month» «Staff Assigned»	
Phone #	<b>(617) 847-4350 x 100</b>	FAX #	<b>(617) 479-3105</b>

Citizens Bank may provide account information, including but not limited to, opening date, balance and average balance of all accounts listed above and additional accounts not listed. Citizens Bank shall be held harmless from and against any claim or loss suffered or incurred as a result of the release of use of information here requested.

**\*\*\*IF THERE ARE NO HOUSEHOLD ACCOUNTS AT THIS BANK, THIS FORM IS NOT NEEDED\*\*\***

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## GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

Name: x \_\_\_\_\_ Address: x \_\_\_\_\_

Daytime Phone: x \_\_\_\_\_

I the above named individual hereby authorize the Quincy Housing Authority (QHA) to verify the accuracy of information that I have provided for myself and all authorized household members from the following sources:

- |                                     |                                     |
|-------------------------------------|-------------------------------------|
| Social Security Administration      | Department of Public Welfare        |
| Veterans Administration             | Courts                              |
| Department of Defense               | Financial Institutions              |
| U.S. Postal Service                 | Sources of Annuities/Pensions       |
| Law Enforcement Agencies            | Landlords: Past & present           |
| Schools & Colleges                  | Employers: Past & Present           |
| Pharmacies                          | Child Care Providers                |
| Sources for Child Support & Alimony | Department of Employment & Training |
| Other _____                         |                                     |

I understand that the information, which will be collected by the QHA, is used to manage the housing programs, to protect the public's financial interest and to verify the accuracy of the information submitted. When permitted by law, it may be released to government agencies, other housing authorities and to court or criminal investigators and prosecutors. Otherwise, the information will be kept confidential and used only by the QHA staff in the course of their duties. I hereby give you permission to release information to the QHA subject to the conditions listed above. I would appreciate your prompt attention in supplying the information requested on the attached page to the QHA within five (5) days of receipt of this request. This authorization is valid for a period of One (1) year from the date noted below. I understand that a photocopy of this authorization is as valid as the original.

X \_\_\_\_\_  
Applicant/Participant Signature

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Applicant/Participant Signature

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Applicant/Participant Signature

\_\_\_\_\_  
Date

«Annual\_Month» «Staff\_Assigned»

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## MEDICAL EXPENSE VERIFICATION

**PLEASE NOTE** THE DATES OF SERVICE LISTED BELOW AND SUBMIT PROOF OF PAYMENT/ RECEIPTS FOR PAID OUT-OF-POCKET EXPENSES. DOCUMENTATION OF PAYMENT WILL ONLY BE ACCEPTED FOR SPECIFIED TIME PERIOD LISTED BELOW.

\*If you are submitting receipts of payment for over the counter products you will also need a letter of medical necessity from an authorized medical professional.

**SECTION 1. TO BE COMPLETED BY CLIENT**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

*I hereby authorize the release of this information.*

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

.....  
**SECTION 2. TO BE COMPLETED BY PROVIDER**

Please supply the information requested below regarding the above referenced individual. We will keep this information in strict confidence and use it only to determine eligibility or rent. Your prompt return of this information is appreciated.  
Please mail this form to Quincy Housing Authority, 80 Clay St, Quincy, MA 02170 ATTN: Leased Housing Department OR FAX: 617-479-3105.

**«Annual Month» «Staff Assigned»**

Leased Housing /HAP SPECIALIST

NAME OF PROVIDER	
ADDRESS	
TYPE OF SERVICE PROVIDED	

DATE OF SERVICES: FROM **JULY 1, 2019** THROUGH **JUNE 30, 2020**

**NOTE: PLEASE PROVIDE TOTAL COST OF PAID OUT-OF-POCKET EXPENSES ONLY. DO NOT INCLUDE AMOUNTS COVERED BY INSURANCE COMPANY. PLEASE BE ADVISED THAT PROOF OF PAYMENT IS REQUIRED.**

TOTAL COST OF OUT-OF-POCKET EXPENSES FOR TIME PERIOD STATED ABOVE: \$ \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PROVIDER

\_\_\_\_\_  
CONTACT NUMBER

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

**\*\* PLEASE NOTE DATES OF SERVICE AND SUBMIT OUT-OF-POCKET EXPENSE VERIFICATION FROM THIS PERIOD OF TIME ONLY. VERIFICATION BEFORE OR AFTER THE GIVEN DATES WILL NOT BE ACCEPTED.**



## APPLICANT/TENANT STATEMENT/CERTIFICATION

1. I / We certify that the information given to the Quincy Housing Authority on household composition, income, net family assets, and allowances and deductions is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal Law. I/We also understand that false statements or information are grounds for termination of housing assistance.
2. I / We understand that any **changes in Income, Assets, or Family Composition** MUST be reported within thirty days of the change.
3. I/We certify that no member of the household is subject to a State lifetime sex offender registration program in any state. If the recertification screening reveals that the head of household or members of the household have falsified information or otherwise failed to disclose criminal history on his/her application or recertification forms, the QHA will pursue termination of assistance.

X \_\_\_\_\_  
Signature Date

X \_\_\_\_\_  
Signature Date

X \_\_\_\_\_  
Signature Date

X \_\_\_\_\_  
Signature Date

### OFFICIAL CERTIFICATION FOR TENANT FILE

I CERTIFY THAT:

1. The information given to the Quincy Housing Authority by the household of **«First Name» «Last Name»** on household composition, income, net family assets, and allowances and deductions has been verified as required by Federal Law.
2. The family was eligible at admission.
3. The family has certified that it has given our agency accurate and complete information.

**«Annual Month» «Staff Assigned»**

\_\_\_\_\_  
PHA Signature

\_\_\_\_\_  
Date

Note: After verification by the Authority, the information will be submitted to the Department of Housing and Urban Development on HUD form 50058. See the federal Privacy Act Statement for more information about its use.