For MCHA use only:

Copy of all forms to:

☐ HCV Dept.

And or

☐ Owned Housing

Staff Initials: _____

Date Received:

MARION COUNTY HOUSING AUTHORITY

2645 Portland Rd. NE · Suite 200 · Salem, OR · 97301
Phone: (503) 798-4170 Fax: (503) 798-4171 TTY: (800) 735-2900

HOUSING CHOICE VOUCHER & PROJECT BASED VOUCHER PARTICIPANTS:
Changes & all required verifications must be reported/submitted by the 15th of any month for a change to be considered for the first of the following month. Decreases reported after the 15th of the month & incomplete packets will be delayed for at least 30 days.

DUE TO COVID-19, INTERIM POLICY WAIVED UNTIL FURTHER NOTICE

HOUSEHOLD INCOME CHANGE FORM

IF YOU OR ANYONE IN YOUR FAMILY IS A PERSON WITH DISABILITIES, AND YOU REQUIRE A SPECIFIC ACCOMMODATION TO FULLY UTILIZE OUR PROGRAMS AND SERVICES, PLEASE CONTACT OUR OFFICE.

▶ **PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY** ◀

Head of Household Name:			Last 4 of SSN:
PHYSICAL Address:	City:	State:	Zip Code:
MAILING Address (if different from physical address)	City:	State:	Zip Code:

Phone:	Msg Phone:	E-Mail:

PROGRAM (check "✓" applicable program/property)

☐ Housing Choice Voucher ☐ VASH ☐ Meadowood ☐ Woodpark Terrace ☐ Farmdale Apartments

☐ Project Based Voucher (Twilight Courts) ☐ Evergreen Court ☐ Creekside Duplexes ☐ Harvest Manor

☐ Oak Park Village ☐ Stayton Elder Manor ☐ Sheridan Senior Estates ☐ Edelweiss Village ☐ Hazelwood Estates

INCOME CHANGE INFORMATION

List the changed household member's income, be sure to fill out and provide all verifications that are required to process your change. Failure to provide the required information may result in a denial of your change. Provide the EMPLOYER NAME, and two (2) current consecutive check stubs reflecting your change or separation letter from employer. For Social Security benefits, unemployment, TANF, etc. provide the current award letter or print out from agency showing new benefit amount.

DATE CHANGE OCCURRED: _____

Name of household member	Income Source (Employer name, social security, TANF, child support, etc.)	Increase or Decrease? (Check one)	Payment Frequency (monthly, weekly, semi-monthly, bi-weekly, etc.)	Do you now have zero income?	Have you applied any other benefits? (Unemployment, TANF, Workers Comp, etc.)
		○ INCREASE ◉ DECREASE		◉ YES* ○ NO	◉ YES, NAME OF BENEFIT ↳ | ○ NO
		◉ INCREASE ○ DECREASE		◉ YES* ○ NO	◉ YES, NAME OF BENEFIT ↳ | ○ NO
		○ INCREASE ◉ DECREASE		○ YES* ◉ NO	○ YES, NAME OF BENEFIT ↳ | ◉ NO
		○ INCREASE ○ DECREASE		○ YES* ○ NO	○ YES, NAME OF BENEFIT ↳ | ○ NO

* COMPLETE ZERO INCOME FORM

FOR FSS PARTICIPANTS ONLY: If you are reporting an income INCREASE, would you like for MCHA to process this change for your household? ○ YES ◉ NO

WARNING: Title 18, Section 1001, of the U.S. 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 U.S. or the Department of Housing and Urban Development. I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation and/or may be grounds for denial of assistance.

Head of Household Signature **Date** **Co-Head/Spouse/Significant Other/Other Adult** **Date**

For MCHA use only:
Date & Time Received

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VERIFICATION OF EMPLOYMENT

MCHA IS REQUIRED TO VERIFY THE EMPLOYMENT STATUS FOR ALL APPLICANTS AND CURRENT PARTICIPANTS IN THE FEDERAL HOUSING PROGRAMS WE ADMINISTER. WE ASK YOUR COOPERATION IN SUPPLYING THE INFORMATION REQUESTED. THE APPLICANT/PARTICIPANT SIGNATURE BELOW AUTHORIZES VERIFICATION OF EMPLOYMENT INFORMATION TO BE RELEASED TO THE MARION COUNTY HOUSING AUTHORITY.

EMPLOYEE INFORMATION

Employee's Full Name: _____ Social Security Number: _____

Employee's Full Address: _____

Employee's Signature: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY EMPLOYER ONLY

INSTRUCTIONS:

- The human resources or personnel staff, supervisor, or accounting staff should complete this form.
- **Under no circumstances should the employee fill out this form.**
- **Only complete section below that applies to employee's current status,** BOX 1, 2 OR 3.
- Please print legibly. You may e-mail the form to **MCHA_INFO@MCHAOR.ORG** or fax to 503-798-4171 **ATTN: HCV DEPT**

1. COMPLETE IF EMPLOYEE IS NO LONGER EMPLOYED

Date of Termination: _____ Last day employee actually worked: _____

Is the employee on Maternity, Parental, Medical or other leave? ◯Yes ◯No *if yes, anticipated return to work date:* _____

Is the employee on short/long-term disability with compensation? ◯Yes ◯No *Amount: $*_____ *Per:* Year

Does the employee have a current or pending worker's compensation claim? ◯Yes ◯No

Do you anticipate re-hiring this employee? Yes No *if yes, when:* _____

2. COMPLETE IF EMPLOYEE IS LAID OFF

Layoff date: _____ Last day employee actually worked: _____

Date employee is expected to return to work: _____ Reason for layoff: _____

Is the employee on Maternity, Parental, Medical or other leave? ◯Yes ◯No *if yes, anticipated return to work date:* ___ __

Is the employee on short/long-term disability with compensation? ◯Yes ◯No *Amount: $*_____ *Per:* Year __

Does the employee have a current or pending worker's compensation claim? ◯Yes ◯No

3. COMPLETE IF EMPLOYEE IS WORKING IRREGULAR, REDUCED HOURS OR ON-CALL

What are the employee's regular hours worked per week: _____ Hourly Rate: $ _____

Reason for change in hours: _____

What are the employee's *NEW WEEKLY* work hours: _____ Date of change of hours: _____

Does the employee receive tips, bonuses or any other compensation? ◯Yes ◯No *Amount: $*_____ *Per:* Week

Date you anticipate the employee's hours to go back to normal schedule: _____

EMPLOYER CERTIFICATION

I HEREBY CERTIFY THAT THE STATEMENTS ABOVE ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Name of Person Completing Form: _____ Phone No.: _____

Employer Name: _____ E-Mail: _____

Address: _____

_____	_____	_____
Signature of person completing form	**Job Tittle**	**Date**

For MCHA use only:
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CERTIFICATION OF ZERO INCOME

FORM TO BE COMPLETED BY EACH ADULT IN THE HOUSEHOLD MEMBER THAT IS REPORTING ZERO (0) INCOME.

▶ COMPLETE PAGE 1 AND 2, ANSWER ALL QUESTIONS, DO NOT LEAVE ANY ITEM BLANK ◀

NAME OF HEAD OF HOUSEHOLD: _____

▶NAME OF ADULT REPORTING ZERO INCOME: _____

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY THE PERSON REPORTING ZERO INCOME.

DO YOU:

Work full-time, part-time, or seasonally ..... ☐Yes ☐ No

Work for someone who pays you cash for day labor..... ☐Yes ☐ No

Own or operate a business ..... ☐Yes ☐ No

Receive regular contributions or does someone ***outside*** your household regularly pay anything on your behalf..... ☐Yes ☐ No

DO YOU RECEIVE OR EXPECT TO RECEIVE:

Unemployment Benefits ..... ☐Yes ☐ No

Social Security Benefits (SSB) ..... ☐Yes ☐ No

Social Security Disability (SSD) ..... ☐Yes ☐ No

Supplemental Security Income (SSI) ..... ☐Yes ☐ No

Temporary Assistance to Needy Families (TANF) or General Assistance (GA) ..... ☐Yes ☐ No

Child support or alimony ..... ☐Yes ☐ No

Utility assistance ..... ☐Yes ☐ No

Supplemental Nutrition Assistance Program (SNAP) ..... ☐Yes ☐ No

DO YOU RECEIVE:

Military pay or Veteran's Benefits..... ☐Yes ☐ No

Worker's Compensation or other disability pay ..... ☐Yes ☐ No

Regular income from a pension/annuity/retirement account ..... ☐Yes ☐ No

Income from assets: checking/savings account interest, certificates of deposit,
Stocks/bonds, or income from rental property..... ☐Yes ☐ No

Regular income from a trust fund ..... ☐Yes ☐ No

Financial aid for college or trade school ..... ☐Yes ☐ No

Regular income from recycling bottles/cans, scrap metal, etc. ..... ☐Yes ☐ No

Regular income from selling plasma (blood)..... ☐Yes ☐ No

HAVE YOU:

Received any regular income not listed above ..... ☐Yes ☐ No

Received a lump-sum payment (SS back pay, lawsuit settlement, inheritance, etc.)..... ☐Yes ☐ No

If you answered YES to any of the questions above, please explain:

_____

_____

_____

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY THE PERSON REPORTING ZERO INCOME. ANSWER ALL QUESTIONS, DO NOT LEAVE ANY ITEM BLANK.

HOUSEHOLD EXPENSES

Please enter the amount **YOU** pay each month. If no payment is made, please write "None" or 0.

Rent: $	Telephone: $	Child Care: $
Electric: $	Cable TV: $	Medical: $
Gas: $	Car Fuel/Maint: $	Credit Card Payment: $
Oil: $	Car Payment: $	Loan Payment: $
Water/Sewer: $	Car Insurance: $	Rentals: $
Garbage: $	Other Insurance: $	Food: $
Personal Items: $	Other expenses: $	Other expenses: $

BANK ACCOUNTS

DO YOU HAVE A BANK OR CREDIT UNION ACCOUNT? ..... ☐YES ☐ NO

Financial Institution name_____ Account Balance $_____

Financial Institution name_____ Account Balance $_____

PREVIOUS EMPLOYMENT & UNEMPLOYMENT HISTORY

WERE YOU PREVIOUSLY EMPLOYED? ..... ☐YES ☐ NO

Employer Name_____Employed from:_____ to:_____

Employer Name_____Employed from:_____ to:_____

WERE YOU PREVIOUSLY RECEIVING UNEMPLOYMENT BENEFITS? ..... ☐YES ☐ NO

PERSONAL CERTIFICATION

Please explain how you are currently providing for your personal needs at this time, for example, is someone else in the household providing (paying) for anything on your behalf, do you receive SNAP benefits, donations from church or other service agencies, etc. Complete the following statement must describing how you are able to provide for your needs:

▶ I AM ABLE TO PROVIDE/PAY FOR MY NECESSITIES BY_____

_____

_____

_____

CERTIFICATION

I/we do hereby swear and attest that all of the information reported on this form about my family and me is true and correct. I/we understand that Marion County Housing Authority is required to verify the information that I/we have reported. I/we understand that any misrepresentation of information or failure to disclose information requested may be grounds for termination and or denial of assistance and is punishable under Federal law.

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.

Signature of Adult Reporting Zero Income	Printed Name of Adult Reporting Zero Income	Date
Signature of Head of Household	Printed Name of Head of ad of Household	Date