



**Select Program:**

My Home

Housing First

Date \_\_\_\_\_

**BASIC INFORMATION**

**NEW APPLICANT: COMPLETE ITEMS 1 & 2**

1. Housing Applicant:

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

2. Case Manager:

Name \_\_\_\_\_ Agency \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City \_\_\_\_\_ State WI Zip Code \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE OFFICE USE ONLY**

3. \_\_\_\_\_ # of Bedrooms

4. \$\_\_\_\_\_ Fair Market Rent (FMR)

5. \$\_\_\_\_\_ Contract Rent

6. \$\_\_\_\_\_ Total of Utility Allowance

7. \$\_\_\_\_\_ Total Rent (Lines 4 & 5)

8. \$\_\_\_\_\_ Tenant's share of rent

9. \$\_\_\_\_\_ County's share of rent

10. \$\_\_\_\_\_ Security Deposit

11. HQS PASSDATE: \_\_\_\_\_

12. Lease: Effective Date: \_\_\_\_\_

Termination Date: \_\_\_\_\_

Utility Allowance

				T	LL
\$_____ Heat	<input type="checkbox"/> Gas	<input type="checkbox"/> Elec.	<input type="checkbox"/> Oil	<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Hot Water	<input type="checkbox"/> Gas	<input type="checkbox"/> Elec.		<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Cooking	<input type="checkbox"/> Gas	<input type="checkbox"/> Elec.		<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Electricity/Lighting				<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Water/Sewer				<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Range				<input type="checkbox"/>	<input type="checkbox"/>
\$_____ Refrigerator				<input type="checkbox"/>	<input type="checkbox"/>

Fixed Charges: \$\_\_\_\_\_ Gas      \$\_\_\_\_\_ Elec.

6. Total Utility Allowance \$ \_\_\_\_\_

13. Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by \_\_\_\_\_ Date \_\_\_\_\_





### APPLICATION

This form must be completed in your own handwriting. You must use the correct legal name for each member of your household as it appears on the Social Security card. All adult members of the household must sign below certifying the information pertaining to them. Please print.

DATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

APPLICANT'S NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

#### 1. HOUSEHOLD COMPOSITION

NAMES OF HOUSEHOLD MEMBERS (include middle initial)	RELATIONSHIP	SEX	OCCUPATION	PLACE OF BIRTH	DATE OF BIRTH	AGE	SOC SEC #
1.	Head of Household						
2.							
3.							
4.							
5.							
6.							

(Check one)     Black     White     Asian     American Indian     Hispanic     Pacific Islander

#### 2. INCOME

FAMILY MEMBER NO.	EMPLOYER NAME/ADDRESS	MONTHLY WAGE	NO. HOURS PER WEEK	SOCIAL SECURITY/ PENSION I.D. NO.

FAMILY MEMBER NO.	SOCIAL SECURITY	PENSION	SSI	AFDC	CHILD SUPPORT/ALIMONY	SOCIAL SECURITY/ PENSION I.D. NO.



3. **ASSETS** List all accounts, including checking, savings, IRA's, Certificates of Deposit, stocks, etc., of all household members)

NAME OF FAMILY MEMBER	BANK NAME	TYPE OF ACCOUNT	ACCOUNT NUMBER

4. **REAL ESTATE** Do you own real estate?  Yes  No  
 Have you sold/given away real estate/other assets in the past 2 years?  Yes  No

5. **CHILD CARE** Do you pay for child care?  Yes  No

Name \_\_\_\_\_ Address \_\_\_\_\_

6. **ELDERLY ONLY** Do you have medical insurance?  Yes  No (need verification)  
 Do you pay for prescriptions?  Yes  No (need verification)  
 Do you pay doctor bills?  Yes  No (need verification)

7. **MEDICAL EXPENSES** Attach all medication and health insurance receipts if you are elderly or handicapped only. **If these receipts are on a regular basis, bring in a yearly printout from your pharmacist or monthly average statement.**

8. **LIFE INSURANCE** If you have life insurance, answer the following:  
 Name of Insurance Co. \_\_\_\_\_  
 Agent \_\_\_\_\_  
 Address \_\_\_\_\_  
 Policy Number(s) \_\_\_\_\_

**Any known change of family circumstance that is going to occur within three (3) months of making application has to be reported when application is made.**

**APPLICANT CERTIFICATION:** I/We certify that the information given to the Milwaukee County My Home Housing Program on household composition, income and assets 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 and termination of tenancy. I do hereby swear and attest that all of the information above about me is true and correct. I also understand that all changes in the income of any member of the household as well as any changes in the household members must be reported to Milwaukee County Rent Assistance in WRITING IMMEDIATELY.

**If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-free Hot Line at 1-800-669-9777 or 1-800-927-9275 (TDD).**

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

Signature of Spouse \_\_\_\_\_ Date \_\_\_\_\_



**HD** Housing  
Division

A Division of the  
Department of Health  
& Human Services

**BIRTH DATE/PLACE CERTIFICATION**

(To be completed by new clients only.)

I, \_\_\_\_\_ hereby certify that I am unable to immediately secure my Birth Certificate. I understand that I am obligated to continue to make efforts to secure my Birth Certificate.

In lieu of my Birth Certificate, I will certify that my date and place of birth are as follows:

Place of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Housing Representative





**DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS**

(To be completed by new clients only.)

U. S. Department of Housing & Urban Development (**HUD**) rule requires that a participant certify **one** of the following:

I, \_\_\_\_\_, certify that I am a citizen of the United States of America and am signing this statement under penalty of perjury.

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

*or*

I, \_\_\_\_\_, certify that I am 62 years or older and a noncitizen of the United States of America. I am receiving assistance under a covered program. I am providing evidence of my age. I am signing this statement under penalty of perjury.

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

*or*

I, \_\_\_\_\_, have an eligible immigration status and have documents from the Immigration and Naturalization Service to verify my noncitizen status. I am signing this statement under penalty of perjury.

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

**For each minor child, a declaration must be signed by an adult residing in the household who is responsible for the child (print names of all children on line below).**

I certify that the minor children living in my household, \_\_\_\_\_

are citizens of the United States of America. I am signing this statement under penalty of perjury.

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





### PROXY STATEMENT

I authorize \_\_\_\_\_ to be my proxy and to carry out program responsibilities on my behalf.

\_\_\_\_\_  
Print Name of Head of Household

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number-Day Telephone Number-Evening

\_\_\_\_\_  
Social Security Number of Head of Household

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

I, the above-mentioned proxy, will explain all information provided by the My Home Housing Program and accept full responsibility for submitting/returning the proper forms and information to the My Home Housing Program on behalf of the above-signed applicant/participant:

\_\_\_\_\_  
Signature of Proxy Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Relationship to Applicant/Participant

\_\_\_\_\_  
Telephone Number-Day Telephone Number-Evening





**RELEASE OF INFORMATION AUTHORIZATION**

Re: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

To Whom It May Concern:

The above-named applicant/participant has applied to the Milwaukee County My Home Housing Program for housing assistance.

Milwaukee County is required, by law, to confidentially verify information provided by applicants/participants. This includes verifying all wage and claim information of all applicants and participants (and members of their family over the age of 18) who apply for participation or when their continuing eligibility in the program is determined.

Wage and claim information will be collected by the Program through the State Wage Information Collection Agency (SWICA) specifically the State of Wisconsin Department of Industry, Labor and Human Relations.

In addition, Milwaukee County is required to verify other types of information. The applicant/participant has shown your Agency's/Organization's name as a source of information. Verification of applicant/participant statements is not limited to those shown in the following authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

Family Composition  
Income  
Wage and Claim Information  
Alimony  
Child Support

Educational Scholarship & Stipends  
W-2  
Assets  
Medical Information  
Child Care Expenses and/or Unusual Expenses

I hereby authorize the Milwaukee County My Home Housing Program to make any inquiries necessary or advisable in verifying information regarding my eligibility for benefits. I further authorize the My Home Program to request the State Wage Information Collection Agency to release wage and claim information relative to my eligibility in the Program.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

*The use of information obtained by the My Home Housing Program from a State Wage Information Collection Agency is restricted, by law, to official purposes.*





**HD** Housing  
Division

A Division of the  
Department of Health  
& Human Services

**ACCESS TO SUPPORT SERVICE INFORMATION**

Re: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

I hereby authorize access to my support service records and information to the My Home Housing Program and the Department of Housing and Urban Development (HUD). The My Home Housing Program and HUD may review any and all records necessary to confirm my eligibility for the Program and to confirm that appropriate services are being delivered in accordance with my plan, that I am in compliance with my plan, and that services delivered are accurately reflected in the Monthly Service Match Report. I further authorize my Case Manager to provide information and to discuss my case as it relates to my eligibility for housing benefits.

I understand that this authorization is for purposes of determining eligibility for and compliance with the rules and regulations of the (Shelter Plus Care) My Home Housing Program.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



# Authorization for the Release of Information/ Privacy Act Notice

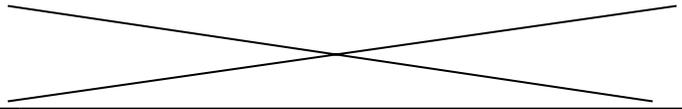
to the U.S. Department of Housing and Urban Development (HUD)  
and the Housing Agency/Authority (HA)

**U.S. Department of Housing  
and Urban Development**  
Office of Public and Indian Housing

PHA requesting release of information: **(Cross out space if none)**  
(Full address, name of contact person, and date)

Milwaukee County My Home Housing Program  
600 W. Walnut Street, Suite 100  
Milwaukee, WI 53212  
Telephone: (414) 278-4902

IHA requesting release of information: **(Cross out space if none)**  
(Full address, name of contact person, and date)



**Authority:** Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

**Purpose:** In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

**Uses of Information to be Obtained:** HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. Private owners may not request or receive information authorized by this form.

**Who Must Sign the Consent Form:** Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:PHA-owned rental public housing

- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

**Failure to Sign Consent Form:** Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

**Sources of Information to be Obtained:** State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only). (This consent is limited to the wage and self-employment information and payments of retirement income as referenced at Section 6103(1)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only). (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

**Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.**

This consent form expires 15 months after signed.

Signatures:

_____	_____	_____	_____
Head of Household	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Social Security Number of Head of Household		Other Family Member over age 18	Date
_____	_____	_____	_____
Spouse	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date

**Privacy Act Notice.** Authority: The Department of Housing and Urban Development (HUD) is authorized to collect his information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et.seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, state, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

**Penalties for Misusing this Consent:**

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure m9m8mproper use.



# Wisconsin HMIS Client Informed Consent and Release of Information

**PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES**  
*Please read the following notice and authorization (or ask to have it read to you) before signing.*

This agency \_\_\_\_\_ participates in the Wisconsin statewide Homeless Management and Information System. Agencies that participate in the Wisconsin HMIS belong to an internet-based network. This network is administered by the Institute for Community Alliances. The name of the software that stores this data is called WellSky Community Services, formerly known as ServicePoint.

<b>Benefits to Data Sharing for the Consumer</b>	
Eliminates Duplicate intakes	Faster access to the Coordinated Entry System, resulting in receiving services more quickly
Reduces the amount of time spent answering basic questions regarding your situation	Allows agencies to focus on meeting your unique service needs
Reduces the amount of times you have to tell your story to service providers	Multiple Services can be easily coordinated and streamlined

*\*WellSky ensures the security of its system. Please see below for detailed information on security measures.*

Because this network is made up of many service providers in Wisconsin, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in the WI HMIS will be shared, with your written consent, in the network. WI HMIS includes your demographic information and other essential personal information needed to best determine your service needs.

The computer program used for this purpose has industry standard security protocols and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the network, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department in the Federal Government, other than Federal departments that are providing services within our network (for example, Veterans Affairs). Personally identifying information will not be shared with any State or Federal department for the purposes of determining your eligibility in other State or Federal programs (for example, Food Share). Information collected is housed in a secure server owned and hosted by WellSky in Arizona. Limited WellSky staff have access to this server and the data for the purposes of network support and maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

*The list of agencies participating in the network can be accessed on the ICA website here, [HMIS Release of Information](#). This list may change.*

**Please note if you grant permission for your information to be shared, that agreement will be in effect until you revoke it in writing. You may end your agreement in writing and your personal and service information will no longer be shared from that date going forward. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.**

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share your information with other agencies, federal and state regulations may require limited data collection for funding purposes.



# Wisconsin HMIS Client Informed Consent and Release of Information

## Type of Information to be shared:

- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Gender, Race Ethnicity, Last Residence Information, Military Status
- Housing/Program Specific: Program Eligibility, Entry/Exits, Agency Assessments, Services, Coordinated Entry, Case Notes, Referrals
- Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence

## \*Please indicate your choice regarding data sharing\*

### Option 1: Verbal Consent

- \_\_\_\_\_By initialing here, I agree to share my and my child/children's above specified information and coordinate services with all participating agencies in the network.

### Option 2: Verbal Consent

- \_\_\_\_\_By initialing here, I agree to limit sharing of my and my child/children's above specified information and coordination of services with this agency and the agencies listed below:

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### Option 3: Verbal Consent

- \_\_\_\_\_By initialing here, I agree I do not want to share my and my child/children's above specified information and coordinate services with other agencies.

I understand that signing below relates only to data sharing within the WI HMIS and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

Print Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Adult #2 Print Name: \_\_\_\_\_

Adult #2 Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verbal Consent obtained by phone (Agency Staff Initials): \_\_\_\_\_ Date: \_\_\_\_\_



### HOUSEHOLD EBL SURVEY

Head of Household Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Please answer the following questions.

YES NO

- Do you have children under 18 years of age residing in your household?  
**If NO, stop and sign below. If YES, continue.**
- Do you have children under 6 years of age residing in your household?  
**If NO, stop and sign below. If YES, continue.**
- Has any child under the age of 6 years been tested for lead poisoning?  
**If NO, stop and sign below. If YES, continue.**
- Has any tested child been identified as positive for an elevated blood lead level?  
**If NO, stop and sign below. If YES, continue.**

Please list all household members under age 6 with an elevated blood lead level.

	Full Name	Male or Female	Date of Birth	Social Security No.	Blood Test Date	Place Tested
1.						
2.						
3.						
4.						
5.						
6.						

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

Address \_\_\_\_\_  
Street City Phone





## HOUSEHOLD FINANCIAL RESOURCES INVENTORY

The My Home Housing Program requires annual verification of your household financial resources. You must report and provide current documentation for **all sources** of income for **all** household members. Program staff will determine whether or not it should be included when completing the Tenant Rent calculations. Please complete the chart below, using the full amount before any deductions. Write \$0 if you do not receive a resource. Failure to report accurate household income is grounds for termination of housing assistance.

		Other Household members				
		Head of Household	Name 1	Name 2	Name 3	Name 4
1	<b>Earned Income</b> includes, but not limited to wages, salaries, overtime pay, commissions, fees, tips, bonuses, other compensation for services					
<b>Social Security</b>						
> SSI - Federal						
> SSI - State						
> SSDI						
Retirement (Social Security)						
3	Pension from Former Job					
4	Veteran's Disability					
5	Veteran's Pension					
6	Payments in lieu of earnings: Unemployment, worker's compensation, disability compensation, severance pay					
<b>Public Assistance:</b>						
> TANF or Equivalent						
> W-2						
> IDAP						
> FoodShare						
> Other (specify)						
8	Child Support					
9	Alimony (Spousal Support)					
10	<b>Periodic payments</b> from annuities, insurance policies, retirement funds, pensions, disability or death benefits or other periodic payments					
11	<b>Lump sum additions</b> including inheritance, insurance payments, settlements, deferred payments of SSI income and social security benefits					
<b>Other Source(s) (specify) Use additional sheet if necessary.</b>						
12						

I certify that the information given to the Milwaukee County My Home Housing Program on household income is accurate and complete to the best of my knowledge.

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

I have reviewed this information with my client and certify that the information given to the Milwaukee County My Home Housing Program on household income is accurate and complete to the best of my knowledge.

Signature of Case Manager \_\_\_\_\_ Date \_\_\_\_\_



**EMPLOYER'S STATEMENT**

RE \_\_\_\_\_  
(Name)

SS# \_\_\_\_\_

Regulations require Milwaukee County to verify the household members' employment to determine their eligibility for Housing assistance. We request that you furnish the information requested. The above named individual authorizes you to release this information.

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

\_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Date of Hire Earnings Yr. to Date Base Rate/Hour Hours/Week

**Employer Verification**

Number of weeks worked per year \_\_\_\_\_

Paid  Weekly  Bi-Weekly  Semi-Monthly  Monthly

Anticipated Increase \$ \_\_\_\_\_ Date \_\_\_\_\_  
(Per Hour/Month)

Date of Termination \_\_\_\_\_

**This form should be completed by a bona fide representative of the employer. In no event, should it be completed by the employee. Federal statutes provide severe penalties for any fraud, intentional misrepresentation, or criminal connivance or conspiracy.**

Company Name \_\_\_\_\_

Signature of Employer's Representative \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Telephone \_\_\_\_\_







## STATEMENT OF RESPONSIBILITIES

I, as a Participant in the My Home Housing Program, fully understand and agree to the following:

1. I must report all household income from all sources, and the names and Social Security numbers of all persons who are living in the household during the course of the lease year.
2. If, at any time during the year, anyone moves in or out, I must report it immediately to the My Home office. A person who stays more than a total of thirty (30) days in any lease year or who uses my address as his/her official address, is presumed to be a resident of my household.
3. I must supply such certification, release information, or documentation as the My Home Housing Program or the U.S. Department of Housing and Urban Development (HUD) determines to be necessary in the administration of the Program. I understand that I must attend my interview appointments and complete my responsibilities in the time specified by the My Home Housing Program. I understand that I must fulfill all my annual recertification responsibilities as specified by the My Home Housing Program.
4. I understand that I must use my dwelling unit solely for my residence. It shall be my principal place of residence; and I will not assign the assisted lease or transfer the dwelling unit. I further understand that I must maintain the dwelling unit in a clean and tenantable manner; and that I must comply with all provisions of the lease.
5. I understand that I must report, in writing, any decreases or increases in household income within ten (10) days during the lease year.
6. I understand that I must reimburse the My Home Housing Program for any overpayment of housing assistance resulting from any failure to report income changes that occur.
7. I understand that I must allow the My Home Housing Program to inspect my dwelling unit at reasonable times and after reasonable notice. I further understand that I must be present during my scheduled inspection and allow the inspector full access to my dwelling unit and related facilities.
8. I understand that I must comply with the lease and occupy the unit for the full term of the lease (unless notice to vacate is given in accordance with the lease).
9. I understand that if I am evicted, I may not be eligible for further benefits from the My Home Housing Program.
10. I understand that the My Home Housing Program paid a full security deposit to my landlord on my behalf. I understand that the Program is entitled to the return of that security deposit at the end of my tenancy. If the owner makes a charge against the security deposit and/or files a claim for damages or vacancy loss under the Housing Assistance Payments Contract, I will be responsible for repaying, to the My Home Housing Program, all amounts paid out on my behalf.
11. I understand that neither I, nor anyone in my household, shall commit fraud in connection with the My Home Housing Program.
12. I understand that neither I, nor anyone in my family, shall receive assistance under the My Home Housing Program while occupying or receiving assistance for occupancy of another dwelling unit assisted under any federal housing assistance program (including any Section 8 program).
13. I understand that my assistance may be terminated if a preponderance of evidence exists which indicates I, or anyone in my household, have engaged in a drug-related criminal activity or violent criminal activity.
14. I understand that I am responsible for any HQS violations caused by my household and guests. Failure to either repair the deficiencies or reimburse the landlord for the reasonable cost of the repairs may result in my termination from the My Home Housing Program. I also understand that I must pay for utilities that are not paid for by the landlord. Failure to maintain utilities is a violation of HQS and could result in my termination from the Program.
15. I understand that I must comply with the service plan developed by my case manager. Failure to fully participate in the specified services may result in my termination from the My Home Housing Program.
16. I understand that I must fulfill all the annual recertification responsibilities if I wish to remain eligible for benefits.
17. I understand that information from the My Home records will be shared, as permitted by law, with the Milwaukee County Department of Health & Human Services and all affiliated partners.

\_\_\_\_\_  
Participant signature

\_\_\_\_\_  
Date

For office use only

\_\_\_\_\_  
Date received

