



HD Housing
Division

A Division of the
Department of Health
& Human Services

Select Program:

My Home

Housing First

TENANT ANNUAL RENEWAL/VERIFICATIONS

Prior to the interview, the Case Manager should begin collecting the verification information. All of the following items that apply to the Tenant must be verified and given to the Housing Representative before the Tenant can be determined eligible for another year of housing benefits.

- Birth Certificates (for all new household members)
- Social Security Card (for all new household members)
- Income Verification
 - Social Security/SSI award letter
 - Pension or Retirement Income
 - Veteran's Benefits
 - Welfare
 - Employment
 - Alimony or Child Support
 - Unemployment Compensation
 - Worker's/Disability Compensation
 - Any Other Income Source
- Assets
 - Savings
 - Checking
 - Savings Certificates
 - Stocks/Bonds
 - Real Estate Holdings
 - Life Insurance (cash value)
- Medical
 - Title 19 Card
 - Medical Card
 - Insurance Premiums
 - Medical Payment Plan for outstanding bills
 - Pharmacy (Rx) costs for prescription drugs (printout or payment plan)
- Child Care
 - Day Care costs (if applicable)
- Household Relationship
 - Verification of the legal or blood relationship of new household members (if applicable)

(All verification information must be supplied by the source and must contain adequate information to allow for the projection of income and expenses for 12 months, e.g., employment verification should include hourly rate, hours per week working, weeks per year working.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES - SPECIAL NEEDS HOUSING PROGRAMS
600 W. Walnut St., Suite 100 ♦ Milwaukee, Wisconsin 53212
Telephone: (414) 278-4902 ♦ Fax: (414) 223-1815



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

Email address

Relationship to Applicant/Participant

Telephone Number-Day Telephone Number-Evening





SECURITY DEPOSIT RETURN

Milwaukee County has paid the security deposit on behalf of the tenant. When the tenant moves, the **case manager should discuss the return of the security deposit (to Milwaukee County)** with the landlord. The case manager should also evaluate the condition of the apartment.

Tenant Name _____ Address _____

TO BE COMPLETED BY CASE MANAGER AT THE TIME OF ANNUAL RECERTIFICATION (or anytime a tenant moves)

A. The current lease will be renewed. The tenant will not be moving (please sign at bottom of page).

If the tenant is vacating a unit, as stated above, the case manager must discuss return of the security deposit with the landlord and complete items 1, 2, 3, and 4 below.

B. The current lease will not be renewed. The tenant will be moving (complete items 1 through 4 below and sign).

C. The tenant is moving prior to lease expiration (complete items 1 through 4 below and sign).

1. Security Deposit (check appropriate box)

- I discussed return of the security deposit with the landlord and the landlord will return the deposit to Milwaukee County. **A check will be made payable to Milwaukee County and sent to My Home Housing Program.**
- I discussed the return of the security deposit with the landlord. The landlord will withhold funds and send proper notice to the County and tenant, in accordance with state law and the contract.

2. Dwelling Unit

My last visit to the dwelling unit was on _____

The condition of the dwelling unit was _____

3. Vacancy Loss/Damages

- The dwelling unit was damaged, and the landlord will be calling the My Home office for a damage inspection.
- The unit was not vacated in accordance with the lease and/or there is tenant rent due and for Vacancy Loss payment.

4. Repayment

In the event the landlord withholds security deposit or receives a vacancy loss or damages payment, it is my clinical recommendation that (check one):

- The client should be held accountable for repayment of some or all of the money paid out to the landlord. I will contact My Home office to make arrangements for the client to enter into a repayment agreement.
- The client has experienced clinical problems, which may have resulted in the damages to the property or in the rent loss. The client should not be required to repay any amount of money paid out to the landlord.

Case Manager _____ Signature _____ Date _____

Agency _____





ANNUAL RENEWAL 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 _____





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	Earned Income includes, but not limited to wages, salaries, overtime pay, commissions, fees, tips, bonuses, other compensation for services					
2	Social Security					
	> SSI - Federal					
	> SSI - State					
	> SSDI					
3	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					
7	Public Assistance:					
	> TANF or Equivalent					
	> W-2					
	> IDAP					
	> FoodShare					
	> Other (specify)					
8	Child Support					
9	Alimony (Spousal Support)					
10	Periodic payments from annuities, insurance policies, retirement funds, pensions, disability or death benefits or other periodic payments					
11	Lump sum additions including inheritance, insurance payments, settlements, deferred payments of SSI income and social security benefits					
12	Other Source(s) (specify) Use additional sheet if necessary.					

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 _____



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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 _____





**MEDICAL STATEMENT
CERTIFICATION OF DISABILITY**

(To be completed by a licensed medical physician, psychiatrist, psychologist, a.p.n.p., p.a., lcsw or lpc)

Applicant's Name _____ Social Security No. _____

Address _____

Authorization to Release Medical Information: _____
Signature of Applicant/Participant Date

The above named person is applying for participation, or is a current participant, in the My Home Housing Program. My Home is a permanent housing program for individuals who have a disability, primarily severe mental illness, chronic substance abuse and/or HIV/AIDS or related diseases. To determine the applicant's/participant's eligibility, this Program must verify the disability as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

- 1. Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment:**
 - (a) which has lasted or can be expected to last for a continuous period not less than 12 months or more; or
 - (b) which can be expected to result in death; or
 - (c) 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/she has previously engaged with some regularity and over a substantial period of time; or

- 2. The individual has a developmental disability, which is a 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 limitation in three (3) 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,
 - (7) economic self-sufficiency; and
 - (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. A person who has a physical, mental, or emotional impairment which:**
 - (a) is expected to be of long-continued and indefinite duration;
 - (b) substantially impedes his/her ability to live independently; and
 - (c) is of such a nature that such ability could be improved by more suitable housing conditions.

CERTIFICATION OF DISABILITY

Based on the definition listed above, the applicant/participant: does not meet meets the definition of disability required by HUD based on the following criteria 1 or 2 / & 3

Specify Disability: _____

Licensed Medical Physician, Psychiatrist, Psychologist, A.P.N.P., P.A., LCSW or LPC:

Signature _____

Date _____

Print Name _____

Business Telephone Number _____

Address _____

See P. 2 for additional information.



MEDICAL STATEMENT DISABILITY DOCUMENTATION

(To be completed by a licensed medical physician, psychiatrist, psychologist, a.p.n.p., p.a., lcsw or lpc)

To determine the applicant's/participant's eligibility and/or level of subsidy, documentation of disability is required.

For applicants who receive SSI and/or SSDI, a Benefit Verification Letter from the Social Security Administration will meet this requirement. A request for a Benefit Verification Letter can be submitted at the following site: www.socialsecurity.gov/beve

For applicants who do not received SSI and/or SSDI, HUD regulations require a written statement documenting the disability. The written statement must be signed by a licensed medical physician and include the following:

1. Identification of the physical, mental or emotional impairment
2. Explain why the disability is expected to be of long-continued or indefinite duration
3. Describe how it impedes the individual's ability to live independently and
4. Explain how the individual's ability to live independently could be improved by living in more suitable housing conditions.

The Milwaukee County My Home Housing Program is a permanent housing program for homeless disabled individuals. Specific targeted disabilities for this program are severe mental illness, chronic substance abuse problems or AIDS and related diseases.