HOUSING AUTHORITY OF SAN ANGELO

420 E 28th ST, San Angelo, TX 76903
(325) 481-2500 Fax (325) 481-2506

HCV Annual Re-Examination Form

Participant Name ____________________
Current Mailing Address ____________________
City/State/Zip ____________________
Home Phone: (_____)__________ Work No. (_____)__________
Mobile No. (_____)__________ Message No. (_____)__________
Email Address: ____________________

If you or anyone in your family is a person with disabilities, and you require a special accommodation in order to fully utilize our programs and services, please contact the HASA.

PART 1: HOUSEHOLD COMPOSITION

Starting on the first line for the Head of Household, please supply the following information for all adults and children that will live in the assisted unit. List other adults first, then children in order from oldest to youngest. Please use the codes listed below for Box 2 reporting the relationship to the head of household for each adult and child listed.

H = Head of Household	A = Other Adult	E = Full time student over 18	F = Foster Child/Adult
K = Co-head of Household	L = Live-in Aide	S = Spouse	Y = Youth under 18

1. Head of Household Full Name (as is on SS Card)	2. Relation H	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		
1. Household Member's Full Name (as is on SS Card)	2. Relation	3. Date of Birth	4. Age	5. Sex	6.Disabled ☐ Yes ☐ No
7. Race (check applicable) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other	8. Ethnicity (check one) ☐ Hispanic ☐ Not Hispanic		9. Social Security Number		

PART 1 continued:

1. Are you or any adult in the household listed on the previous page a part-time or full-time student enrolled in a school of higher education? ☐ Yes ☐ No

    a. If yes, do you receive financial assistance? ☐ Yes ☐ No

    b. If yes, you will be required to provide proof of enrollment status, a print out from the school of attendance to indicate financial aid assistance you receive by type, and an itemized cost list from the school as well.

2. Do you wish to move? ☐ Yes ☐ No If yes, please explain: _____

PART 2: ASSET INFORMATION

1. Do you or any household member (regardless of age) own any bank accounts including checking accounts, savings accounts, other bank accounts, stocks, bonds, CD's, trusts, or cash? ☐ Yes ☐ No

    If yes, please complete the chart below for all household member(s) accounts:

Account Holder's Name	Type of Account (ckg, svg, CD, other)	Partial Account Number	Current Estimated Balance	Income/interest earned on the account ($ or %)	Bank Name and Fax Number
			$		
			$		
			$		
			$		

2. Has any member of your family given away or disposed of assets valued at more than $1000.00 for less than fair market value during the past two years? ☐ Yes ☐ No

3. Do you have any present ownership interest in any real property at the time of this review? ☐ Yes ☐ No

    a. If yes, do you have the effective legal right to reside in the real property? ☐ Yes ☐ No

    b. If yes, do you have the effective legal authority to sell the real property? ☐ Yes ☐ No

    c. If yes, is there a co-ownership agreement in place or is the property tied up in litigation? ☐ Yes ☐ No

PART 3: INCOME INFORMATION FOR ASSISTED HOUSEHOLD

1. Does any member of your household consider themselves to be a seasonal worker, day laborer, or independent contractor (i.e. self-employed)? ☐ Yes ☐ No

2. Does any member of your household currently receive worker's compensation in lieu of wages? ☐ Yes ☐ No
    a. If yes, how long has this member received worker's compensation payments? _____
    b. If yes, how long does this member expect to receive worker's compensation payments? _____

3. Does any member of your household currently receive or expect to receive regular contributions from organizations or from individuals not living in the unit? ☐ Yes ☐ No

4. Did you file a Federal Tax Return last year? ☐ Yes ☐ No
    a. If yes, how much was the return? _____
    b. If yes, did you deposit into the account? _____
    c. If yes, what date did you receive the income tax return? _____

5. Do you or any household member have income that will not be repeated in the coming year, i.e. nonrecurring income? ☐ Yes ☐ No
    a. If yes, how long do you anticipate receiving this income? _____(e.g. 1 week, 3 months, 6 months, etc.)
    *Please note that if it is found that the reported nonrecurring income extends over a year, it will be counted.

6. Within the last year, have you received any type of lump sum payment from any source? ☐ Yes ☐ No
    a. If yes, what was the source of the lump sum payment? _____
    b. If yes, what was the total amount of the lump sum payment? _____

7. Did you report an interim change since your last annual re-examination review? ☐ Yes ☐ No

8. Do you need to report any permanent changes in income with this review? ☐ Yes ☐ No

    If yes, please explain: _____

Please list ALL gross income (before taxes) for each family member in the boxes below. The top two rows are for working income, worker's compensation, student loans/grants, military pay, regular contributions from outside individuals or agencies, or other income not listed below. If you have questions on where income should be reported, please ask.

Name of Family Member Receiving the Income	Gross Payment	Frequency (how often)	Name of Source or Employer	Address / Phone Number of Source or Employer

Specific Type of Income	Name of Person Receiving the Income	Amount	Frequency (how often)
SOCIAL SECURITY			
SSI			
PENSION/RETIREMENT/ ANNUITY			
VETERANS BENEFITS			
UNEMPLOYMENT			
ALIMONY/CHILD SUPPORT			
TANF			
SNAP/FOOD STAMPS (will be excluded income)			

PART 5: CARE PROVIDER ALLOWANCE, if not applicable to your family, go to part 6.

You may be eligible to claim the following unreimbursed expenses for the family if the type of care allows a family member to work. Please read each description carefully.

Unreimbursed Child Care Expense	Unreimbursed Disability Assistance Expense
If you pay (and are not reimbursed) for a care provider to care for a child under the age of 13 who is a member of your family so that an adult member of the family may work, actively seek work or attend classes, complete the following information: Name of adult family member who is able to work or attend classes: _____ Name of Provider: _____ Amount paid to provider: $_____How often: _____ Provider's phone number: _____	If you pay (and are not reimbursed) for the care or equipment for a disabled member of your family so that either the disabled member or another member of the family may work, complete the following information: Name of the family member who is able to work: _____ Provider's Name:_____ Amount paid to provider: $_____How often: _____ Provider's phone number: _____ Provider's address: _____

PART 6: MEDICAL EXPENSE ALLOWANCE: Complete only if the Head of Household, Spouse, or Co-Head is age 62 or older or disabled; if not applicable, go to Part 7.

Health and Medical Care expenses are any costs incurred in the diagnosis, care, mitigation, treatment, or prevention of disease or payments for treatments affecting any structure or function of the body. These expenses include Medical Insurance Premiums and long-term care premiums. The expenses will be considered for those expenses that are paid or anticipated during the period for which annual income is computed with this reporting and are not reimbursed to the family by an outside source. You will be asked to provide a payment history for these expenses or a statement of premium. Below, please provide the first name of any family member claiming each expense and the name and address of the provider of the service or product. Please complete the chart on the following page, if applicable and qualified for the expense allowance as described.

Note: Under HUD regulations, the threshold for an expense deduction under this category remains 3% of annual income, i.e. the deduction allowed is the sum of qualified health and medical care expenses in excess of 3% of the calculated annual income.

Unreimbursed Health and Medical Care Expenses	
Family Member Name: _____ Expense Claimed: $_____ Frequency:_____ Provider: _____ Address: _____ City/State/Zip:_____ Phone No.:_____ Fax No.: _____	Family Member Name: _____ Expense Claimed: $_____ Frequency:_____ Provider: _____ Address: _____ City/State/Zip:_____ Phone No.:_____ Fax No.: _____
Family Member Name: _____ Expense Claimed: $_____ Frequency:_____ Provider: _____ Address: _____ City/State/Zip:_____ Phone No.:_____ Fax No.: _____	Family Member Name: _____ Expense Claimed: $_____ Frequency:_____ Provider: _____ Address: _____ City/State/Zip:_____ Phone No.:_____ Fax No.: _____

PART 7: HEAD OF HOUSEHOLD MUST SIGN THIS FORM CERTIFYING ACCURACY OF INFORMATION PROVIDED

I certify that the information given to the Housing Authority of San Angelo (HASA) on this form is true and complete to the best of my knowledge and belief. I understand that false statements or information is punishable under Federal law. I understand that false statements or information are grounds for denial or termination of housing assistance. I understand that I can be fined or imprisoned for furnishing false or incomplete information.

Signature: _____ Date: _____