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Public Housing Authority of San Angelo, Texas
420 E 28th St.
San Angelo TX 76903

Annual Reexamination Form

PART 1: CONTACT INFORMATION

Current Address _____
City/State/Zip _____
Home Phone (__ __ __) __ __ __ - __ __ __ __ Work No (__ __ __) __ __ __ - __ __ __ __
Mobile No (__ __ __) __ __ __ - __ __ __ __ Message No (__ __ __) __ __ __ - __ __ __ __

PART 2: HOUSEHOLD COMPOSITION

1. Member's Full Name	Relation H	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

2. Member's Full Name	Relation	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

3. Member's Full Name	Relation	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

4. Member's Full Name	Relation	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

5. Member's Full Name	Relation	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

6. Member's Full Name	Relation	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

7. Member's Full Name	Relation H	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

8. Member's Full Name	Relation H	Date of Birth	Age	Sex	Disabled □ Yes □ No
Race (check one) □ White □ Black □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander	Ethnicity (check one) □ Hispanic □ Not Hispanic		Social Security Number		

PLEASE LIST THE CHILDREN ATTENDING SCHOOL

Name	Age	School Attending

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PART 3: ASSET INFORMATION

Please list all checking, savings, and other bank accounts, stocks, bonds, CD's, trusts, real estate and cash held by any family member regardless of age.

Family Member Name	Type of Account	Account Number	Current Balance	Name & Address
	1._____	_____	$_____	Name_____
	2._____	_____	_____	Address_____
	3._____	_____	_____	City/State/Zip_____
				Phone# _____ Fax#_____
Family Member Name	Type of Account	Account Number	Current Balance	Name & Address
	1._____	_____	$_____	Name_____
	2._____	_____	_____	Address_____
	3._____	_____	_____	City/State/Zip_____
				Phone# _____ Fax#_____

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

PART 4: INCOME INFORMATION

Did you file a Federal Tax return last year? □Yes □ No
Does anyone living outside your household pay any of your bills? □Yes □ No

Please list gross payments (before taxes) made to each family member age 18 or older for wages, worker's compensation, welfare assistance, food stamps, student loans/grants, social security, SSI, disability, unemployment benefits, retirement payments, child support, military pay, periodic gifts, barter income, business or professional income. Include payments made to family members age 18 or older on behalf of other family members under age 18.

Family Member Name	**Gross Payment**	**Frequency**	**Name and Address of Source**
	$_____	_____	Name_____
			Address_____
			City/State/Zip_____
			Phone#_____ Fax_____
Family Member Name	**Gross Payment**	**Frequency**	**Name and Address of Source**
	$_____	_____	Name_____
			Address_____
			City/State/Zip_____
			Phone#_____ Fax_____

	Name of person receiving	**Amount**	**Frequency**
TANF			
SOCIAL SECURITY			
SSI			
PENSION/RETIREMENT			
VETERANS BENEFITS			
UNEMPLOYMENT			
ALIMONY/CHILD SUPPORT			
FOOD STAMPS			
OTHER			

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PART 5: CARE PROVIDER ALLOWANCE

Unreimbursed Child Care 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, enter the name of the person who works or attends classes here _____, and provide the following information: Amount paid to provider $_____ How often _____ Providers Name _____ Address _____ City/State/Zip _____ Phone # _____ Fax# _____	**Unreimbursed Disability Assistance Expense** If you pay (and are not reimbursed) for care or equipment for a disabled member of your family so that either the disabled member or another member of the family may work, enter the first name of the person who works here:_____, and provide the following information: Amount paid to provider $_____ How often _____ Providers Name _____ Address _____ City/State/Zip _____ Phone # _____ Fax# _____

PART 6: MEDICAL EXPENSE ALLOWANCE

Complete only if the Head of Household, Spouse or Co-Head is age 62 or older or disabled
If you wish to claim an allowance for Medical Insurance Premiums; Medical, Dental or Optical Expenses; or Prescription or Over the Counter Drug Expenses, 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.

Family Member First Name _____ Expense Claimed $_____ Provider_____ Address_____ City/State/Zip_____ Telephone#_____ Fax#_____	Family Member First Name _____ Expense Claimed $_____ Provider_____ Address_____ City/State/Zip_____ Telephone#_____ Fax#_____
Family Member First Name _____ Expense Claimed $_____ Provider_____ Address_____ City/State/Zip_____ Telephone#_____ Fax#_____	Family Member First Name _____ Expense Claimed $_____ Provider_____ Address_____ City/State/Zip_____ Telephone#_____ Fax#_____

You must provide a print out from the pharmacy, signed by the pharmacist and a statement from the doctor advising the PHA of the medications that are prescribed in order to receive a deduction.

PART 7: VEHICLE INFORMATION – PUBLIC HOUSING ONLY

YEAR	MAKE	MODEL

PART 8: HEAD OF HOUSEHOLD MUST SIGN THIS FORM CERTIFYING ACCURACY OF INFORMATION PROVIDED

I certify that the information given to the San Angelo Public Housing Authority 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 termination of housing assistance. I understand that I can be fined or imprisoned for furnishing false or incomplete information.

X_____ Date_____