**420 E 28th ST**
**San Angelo TX 76903**
(325) 481-2500 Fax (325) 659-0160

# Annual Re-Examination Form

## PART 1: CONTACT INFORMATION

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

## PART 2: 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 adults first, then children. Using the codes listed below enter the relationship to the head of household for each adult and child listed.

| | | | |
|---|---|---|---|
| H=Head of Household | K=Co-Head (not married) | Y=Youth under 18 | L=Live-in Aide |
| S=Spouse (married) | F=Foster Child/Adult | E=Full time student Over 18 | A=Other Adult |

| 1. Member's Full Name | 2. Relation<br>H | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation<br>H | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

| 1. Member's Full Name | 2. Relation<br>H | 3. Date of Birth | 4. Age | 5. Sex | 6. Disabled<br>□ Yes □ No |
|---|---|---|---|---|---|
| 7. Race (check one)<br>□ White □ Black □ American Indian/Alaskan<br>□ Asian □ Hawaiian/Pacific Islander | 8. Ethnicity (check one)<br>□ Hispanic □ Not Hispanic | 9. Social Security Number | | | |

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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

If the following items do not apply to your family, go to Part 6.

| **Unreimbursed Child Care Expense**<br>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:<br><br>Amount paid to provider $_________ How often ____________<br><br>Providers Name ______________________________________<br><br>Address ______________________________________<br><br>City/State/Zip ____________________________________<br><br>Phone # ___________________ Fax# __________________ | **Unreimbursed Disability Assistance Expense**<br>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:<br><br>Amount paid to provider $__________ How often ____________<br><br>Providers Name ________________________________________<br><br>Address ______________________________________<br><br>City/State/Zip ______________________________________<br><br>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 ________________________________<br><br>Expense Claimed $_____________________________________<br><br>Provider______________________________________________<br><br>Address______________________________________________<br><br>City/State/Zip__________________________________________<br><br>Telephone#___________________ Fax#___________________ | Family Member First Name ____________________________<br><br>Expense Claimed $____________________________________<br><br>Provider_____________________________________________<br><br>Address_____________________________________________<br><br>City/State/Zip_________________________________________<br><br>Telephone#________________ Fax#___________________ |
|---|---|
| Family Member First Name ________________________________<br><br>Expense Claimed $_____________________________________<br><br>Provider______________________________________________<br><br>Address______________________________________________<br><br>City/State/Zip__________________________________________<br><br>Telephone#___________________ Fax#___________________ | Family Member First Name ______________________________<br><br>Expense Claimed $____________________________________<br><br>Provider_____________________________________________<br><br>Address_____________________________________________<br><br>City/State/Zip_________________________________________<br><br>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: 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______________________________________________