NEW AVENUES TO INDEPENDENCE, INC.

APPLICATION FOR SECTION 8

HOUSING VOUCHER WAIT LIST

To be completed and returned to:

New Avenues to Independence, Inc.
Attn: Section 8 Office
17608 Euclid Avenue
Cleveland, OH 44112

INSTRUCTIONS FOR COMPLETING AND RETURNING APPLICATION:

APPLICATION FILL-IN INSTRUCTIONS

Applications must be completed, in ink, by the Head of Household. The Head of Household must be an adult (18 years or older) with a disability and the legal capacity to enter into a lease. If a guardian or other adult completes the application for the Head of Household, the Head of Household must sign the application on page 6 verifying the accuracy of the information.

MAILING INSTRUCTIONS

New Avenues will rank all applications based on preferences and date of postmark. An application must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service Postmark.
(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service, indicating what was mailed.
(3) Postage to return the completed application is 1 first class postage stamp.

New Avenues **does not accept** either of the following as proof of mailing:
(1) A private metered postmark, or
(2) A mail receipt that is not dated by the U.S. Postal Service.

An applicant should note that the U.S. Postal Service does not uniformly provide a dated postmark. Each late applicant will be notified that its application will not be considered.

Waiting list order is determined by date of postmark on the application received by New Avenues and number of accumulated local preferences based on disability and income. **One application per applicant.** Duplicates will be discarded; the application with the earliest date will be kept by New Avenues. Applications postmarked the same date with the same local preferences will be ranked based on a lottery process and placed on the wait list accordingly. Applicants will be notified of their rank on the wait list by New Avenues.

NEW AVENUES TO INDEPENDENCE, INC.
APPLICATION FOR SECTION 8 WAIT LIST

PLEASE COMPLETE THIS APPLICATION IN ITS ENTIRETY. FAILURE TO PROVIDE TRUE AND COMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION. **DO NOT** LEAVE ANY SPACES BLANK.

PART A: HOUSEHOLD COMPOSITION AND CHARACTERISTICS

1. Legal Name of Head of Household:____

2. Social Security #:______________________ 3. Alien Registration #:______________________

4. Current Address:____

5. Home Phone #:______________ 6. Work Phone #:__________ 7. Spouse Work Phone #:______________

8. Date of Birth:______________ 9: Sex (M/F):________

10. Citizenship – Are you a citizen of the United States (Yes/No)?________If no, please complete box D in #14 below.

11. Race (**1**=White, **2**=Black/African American, **3**=American Indian/Alaska Native, **4**=Asian, **5**=Native Hawaiian/Other Pacific Islander) Select as many codes as appropriate to best indicate your race:______________________

12. Ethnicity (**1**=Hispanic or Latino, **2**=Not Hispanic or Latino):______________________

13. Do you or any member of your household claim any type of disability? (Yes/No)? __________

13a. Do you have a need for a reasonable accommodation in PHA rules or policies, modification of the housing unit, or specific housing needs (Yes/No)?________ If yes, please describe:______________________

____

14. LIST ALL OTHER MEMBERS WHO WILL BE LIVING IN THE UNIT

- **A** - Give the relationship of each family member to the head using the following codes: (**H**=head, **S**=spouse, **K**=co-head, **F**=foster child, foster adult, **Y**=other youth under 18, **E**=fulltime student 18+, **L**=live-in aide, **A**=other adult)
- **B** - Select as many codes as appropriate to best indicate each member's race: (**1**=White, **2**=Black/African American, **3**=American Indian/Alaska Native, **4**=Asian, **5**=Native Hawaiian/Other Pacific Islander)
- **C** - Select the code that best indicates each member's ethnicity: (**1**=Hispanic or Latino, **2**=Not Hispanic or Latino)

Member Number	Member's Full Legal Name	Birth Date	Age	Sex M/F	**A** Relation To Head	U.S. Citizen Yes/No	**B** Race	**C** Ethnicity	**D** Social Security # / Alien Reg #
02									
03									
04									
05									

15. If there are any **additional household members** check here _____ and attach a separate page with application.

PART B: DRUG/CRIMINAL ACTIVITY – FEDERAL REGULATIONS REQUIRE HOUSING AGENCIES TO QUESTION APPLICANTS AND PARTICIPANTS CONCERNING DRUG RELATED OR VIOLENT CRIMINAL ACTIVITIES

1. Have you or any household member ever been evicted from Public or Assisted Housing for violent criminal or drug-related activity (Yes/No)?____ If Yes, provide the following information: When:________________________________
For what reason:____
____Name of Household Member:_____________________________
Name of Public/Assisted Housing:____

2. Have you or any household member ever been convicted of the manufacture or production of methamphetamine (speed) on the premises of Public or Assisted Housing (Yes/No)?_________ If yes, provide the following information: Name of Household Member:____
Name of Public/Assisted Housing:____

3. Are you or any household member subject to lifetime registration as a sex offender (Yes/No)?_________ If Yes, provide the following information: Name of Household Member:_____________________________________

4. Are you or any household member persons who abuse or show a pattern of abuse of alcohol (Yes/No)?________________
If Yes, provide the following information: Name of Household Member:______________________________
Is household member currently enrolled in a treatment program (Yes/No)?__________ If Yes, please describe:_____________
____

PART C: INCOME INFORMATION

Annual Gross Income of Household (Total yearly income of all individuals to live in unit): $______________________

1. **Work full-time, part-time, or seasonally** – including wages, fees, tips, bonuses, money for services (Yes/No)?________________
If Yes, provide the following information:

a. Name of Household Member:	c. Name of Household Member:
Employer Name:	Employer Name:
Employer Address:	Employer Address:
Employer Telephone #:	Employer Telephone #:
b. Name of Household Member:	d. Name of Household Member:
Employer Name:	Employer Name:
Employer Address:	Employer Address:
Employer Telephone #:	Employer Telephone #:

2. Receive Social Security or SSI benefits (Yes/No)?________ If Yes, provide: Household Member Name:______________________

____

Amount:____

Social Security # Benefits are Received Under:____

3. Receive unemployment benefits, workers compensation, or severance pay (Yes/No)?________________ If Yes, provide:

Household Member Name:____

Type of Benefit:____

Amount:____

Employer Name and Address:____

____

4. Receive child support from the child support recovery unit or directly from an absent parent (Yes/No)?_________If Yes, provide:

a. Minor's Name:	c. Minor's Name:
Name of Absent Parent:	Name of Absent Parent:
Child Support Amount:	Child Support Amount:
b. Minor's Name:	d. Minor's Name:
Name of Absent Parent:	Name of Absent Parent:
Child Support Amount:	Child Support Amount:

5. Receive alimony (Yes/No)?____________ If Yes, provide: Household Member Name:_____________________________

Amount:____Former Spouse Name:_______________________________

6. Receive public assistance (TANF) (Yes/No)?____________ If Yes, provide: Household Member Name:______________________

____

Amount:____

7. Receive income from a pension or annuity (Yes/No)?_____________ If Yes, provide: Household Member Name:_______________

____

Amount:____

Type of Pension/Annuity:____

Address of Pension/Annuity:____

Claim #:____

PART E: EXPENSES

1. Indicate the $$ monthly expenditures for your household below:

Rent:	Phone:	Medical:	Credit Card:
Electric:	Car Payment:	Cable:	Credit Card:
Gas:	Car Insurance:	Insurance:	Loan:
Water:	Child Care:	Rentals:	Other:

ELDERLY/DISABLED FAMILIES ONLY

2. Do you pay a care attendant or for any equipment for any household member(s) with disabilities necessary to permit that person or someone else in the household to work? If you pay a care attendant, provide monthly amount:________________________________

3. What is the monthly cost to you for the care attendant and/or the equipment?____

____

4. Do you have Medicare (Yes/No)?______________ If Yes, what is your monthly premium?________________________________

5. Do you have any other kind of medical insurance (Yes/No)? If Yes, provide:

a. Name of Insurance Company:	b. Name of Insurance Company:
Insurance Agent's Name:	Insurance Agent's Name:
Insurance Company Address:	Insurance Company Address:
Monthly Premium Amount:	Monthly Premium Amount:

6. Do you have outstanding medical bills, which you are paying (Yes/No)?____________ If Yes, provide monthly amount:_________

7. Do you expect to incur additional medical expenses in the next twelve months that will not be covered by medical insurance (Yes/No)?____________ If Yes, provide monthly amount:____

APPLICATION/PARTICIPANT CERTIFICATION

I certify that the information given to New Avenues to Independence, Inc. (NATI) on household composition and characteristics, drug and criminal activity, income, assets, and expenses, is accurate and complete. I understand that false statements or information are punishable under Federal Law and grounds for denial or termination of housing assistance.

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.

Signature of Head of Household:____Date:________________________________

Signature of Spouse:____Date:________________________________