

WAITING LIST CHANGE FORM

Warren Metropolitan Housing Authority 990 East Ridge Drive Phone: 513.695.3380 Fax: 513.695.1638

This form must be completely filled out. Failure to do so will result in the change being processed as untimely.

Name of Head of Household: _____ Phone: _____
 Address: _____ Cell: _____

____ YES, the address above is a NEW address

Describe your change (Add/Remove Member, Address Change, Name Change, etc.):

- | | | |
|---|-----|----|
| Are you or anyone in your household working? | Yes | No |
| Have you or anyone in your household lost a job? | Yes | No |
| Are you or anyone in your household receiving child support? | Yes | No |
| Have you or anyone in your household received a lump sum in the last 12 months? | Yes | No |
| Do you or anyone in your household receive Social Security, SSI, SSD? | Yes | No |
| Do you or anyone in your household receive OWF? | Yes | No |
| Do you or anyone in your household receive a pension or other retirement funds? | Yes | No |
| Have you or anyone in your household been approved for workmans comp or disability? | Yes | No |
| Do you pay childcare? | Yes | No |

If you answered yes to any of the above questions, be sure to fill out the corresponding section(s) on the reverse of this form.

Who is living in your household? All household members 18 & older must report all income. Please list the monthly income that each household member receives.

Name	Relationship	DOB	Social Security Number	Income	Source
				\$	
				\$	
				\$	
				\$	
				\$	
				\$	

All changes must be reported within 10 business days.

Important-Please read carefully!

- | | | |
|---|------|----|
| Is your change form complete? We will no longer accept change forms that are not completely filled out. | Yes | No |
| Is each space on this form completed? If it does not apply to you, mark with N/A or NO. | Yes | No |
| Do you have the complete name, address & phone number of your employer? Ask for a phone book! | Yes | No |
| Did you use the name of the person with the change in the brief description? We need to know! | Yes | No |
| Have you listed all household members? That includes everyone who has been there longer than 15 days. | Yes | No |
| Have you listed the household income for each member? Do your math! You may need a calculator. | Yes | No |
| Which waiting list are you currently on? | S8 | PH |
| | BOTH | |

Remember to sign and date your form. Do not leave anything blank.

If you have any questions...please ask! We will be happy to help.

TIME STAMP

Employment

Head of Household

When did employment begin? _____
Company Name: _____
Address: _____
Phone: _____
Fax: _____
How many hours per week do you work? _____
What is your rate of pay? _____ per _____
Do you receive tips, bonuses, commission? _____
Were you hired through a temp. agency? _____
If yes, agency name, address, and phone number: _____

Other Adult

When did employment begin? _____
Company Name: _____
Address: _____
Phone: _____
Fax: _____
How many hours per week do you work? _____
What is your rate of pay? _____ per _____
Do you receive tips, bonuses, commission? _____
Were you hired through a temp. agency? _____
If yes, agency name, address, and phone number: _____

Is there a job loss? Yes No
Where were you working? _____
Address: _____
Phone: _____
Last day worked: _____
Have you applied for unemployment? Yes No

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Where were you working? _____
Address: _____
Phone: _____
Last day worked: _____
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EID Qualification (PH/Disabled S8 only)
Has it been 12 months or longer since you last worked? Yes No
Have you received cash assistance in the last six months? Yes No

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Child Support

Are you receiving Child Support? Yes No
What county & state are your orders in? _____
Do you have an order for Child Support? Yes No

How many cases & what is the amount received?
Case 1 _____ Case 2 _____
Case 3 _____ Case 4 _____

Lump Sum Disbursement

Have you or anyone in your household received a lump sum disbursement? Yes No
If yes, what is the amount & source? \$ _____ source: _____

Benefit Approval

I have been approved for:
Ohio Works First (OWF) SS SSI SSD Pension Workmans Comp Unemployment
\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____

Child Care

Do you pay for child care? Yes No
If yes, amount paid: \$ _____ per _____
If no, when did your child care stop? _____
Do you receive help paying childcare? Yes No Who helps? _____
Name & Address of childcare provider: _____
phone: _____

I/we certify that the information given to WMHA is accurate and complete to the best of my/our knowledge and belief. I/we understand that knowingly supplying false, inaccurate or incomplete information is punishable under Federal and Criminal law. I/we understand that supplying false, inaccurate or incomplete information is grounds for TERMINATION of Housing Assistance.

I/We have read and fully understand the above statements.

Signature of Head of Household

Date

Signature of Spouse/Other Adult

Date

Signature of Other Adult

Date