

**Return Completed Package to:**  
NYC Dept. of Housing Preservation and Development  
Division of Tenant Resources (DTR)  
Project-Based Programs Unit  
100 Gold Street, Room 4N  
New York, NY 10038



**Office of Housing Operations**  
DIVISION OF TENANT RESOURCES

### RENTAL SUBSIDY RECERTIFICATION PACKAGE

(Includes the following programs: Housing Choice Voucher, Shelter Plus Care, and SRO MOD Rehab)

Head of Household Name:

**Case Manager's Name**

Address:

**Complete Package Due On or Before  
(late packages may result in termination):**

Dear Rental Subsidy Participant:

As a participant in the New York City Department of Housing Preservation and Development's (HPD) Rental Subsidy program, federal regulations require that you recertify annually in order to continue to receive assistance. Please:

- Read and complete the top of each page in this package.**
- Complete the "Rental Subsidy Participant Household Summary."
- Have all household members 18 years or older sign:
  - o "Authorization for Release of Information" (Form 1)
  - o "Debts Owed to Public Housing Agencies and Terminations" (Form 10)
- Complete all forms that apply to your household (Forms 2-10)
- Read and complete the recertification checklist to make sure you have included all required documents
- Read, sign, and date the certification statement below.
- Make a copy of this package for your records. If you need additional copies of any forms, please make copies or obtain copies to print out at the following web address: <https://www.nyc.gov/hpd/dtr-forms>.
- Submit the recertification package to HPD:
  - o Online through HPD's secure document upload portal: <https://a806-asap.nyc.gov/HPDPortal/>
  - o By encrypted email to [DTRAI@hpd.nyc.gov](mailto:DTRAI@hpd.nyc.gov)
  - o By fax to 212.863.5299

If you have a disability and need a reasonable accommodation, you can request an accommodation by going to our website <https://www.nyc.gov/hpd/dtr-forms> and submitting a form or by calling 917-286-4300.

**Did Someone Other than an HPD Employee Help You Complete This Recertification Package?**

Name \_\_\_\_\_  
Relationship to You \_\_\_\_\_  
Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
Email \_\_\_\_\_

**Need help?**

Call HPD at 917-286-4300. For more information about HPD's HCV Section 8 policies please refer to HPD's Administrative Plan at [http://www.nyc.gov/html/hpd/html/tenants/section\\_8.shtml](http://www.nyc.gov/html/hpd/html/tenants/section_8.shtml).

**Certification Statement -- Head of Household Please Read, Sign, and Date Below**

**I have read the enclosed HPD Rental Subsidy annual recertification forms and instructions. I have completed my recertification with the most current information on my household's income, assets and family composition. I understand that providing false statements to a government agency is punishable under federal law and may result in the termination of my participation in the Rental Subsidy program. I further understand that HPD will verify my income information with a third party, such as the Enterprise Income Verification database.**

\_\_\_\_\_  
**Head of Household Signature (Required)**

\_\_\_\_\_  
**Today's Date (Required)**



Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

## RENTAL SUBSIDY PARTICIPATING HOUSEHOLD SUMMARY

Do you need assistance in any other language besides English?     Yes     No

If Yes, list the language: \_\_\_\_\_

Please enter all the requested information below. Please provide the supporting documentation described in each section.

**THIS FORM MUST BE COMPLETED BY THE HEAD OF HOUSEHOLD.**

The Head of Household is responsible for all information reported on behalf of household members.

Social Security Number	Last Name	First Name	Daytime Phone Number(s)		
_____					
Address	Apartment	City	State	Zip Code	Email Address

### FAMILY MEMBERS

Household composition must be verified at every recertification and throughout the year if it changes. Please list all household members below and enter the requested information. If there are any changes in the household from the last annual recertification, please provide HPD with supporting documentation.

If any household member has moved or passed away, please complete the "Request to Remove Household Member" (Form 3). If you would like to request to add a household member, please fill out the "Request to Add Household Member" (Form 2).

FULL NAME	FULL-TIME STUDENT	SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH	CITIZENSHIP	IS THIS PERSON DISABLED?
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					





Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**HOUSEHOLD INCOME INFORMATION**

All income for every household member must be reported and verified at every recertification. Please enter all household income below and provide HPD with supporting documentation (such as pay stubs) for all income, **including income from employment, pensions, government benefits, child support**, and all types of income listed in the "What is Income?" form. If income is from employment, complete the "Verification of Wages" (Form 4).

FULL NAME	INCOME DESCRIPTION	FREQUENCY (e.g. weekly, monthly)	AMOUNT	ANNUAL INCOME (if known--if not leave blank)

**HOUSEHOLD BANK ACCOUNTS, ONLINE FINANCIAL ACCOUNTS AND OTHER ASSETS (OTHER THAN REAL ESTATE PROPOERTY)**

All assets in the household must be reported at every recertification. Please enter all assets for all household members, along with the supporting documentation as listed in "Verification of Assets" (Form 5).

If you no longer have an asset that was previously reported to HPD please provide documentation, such as a closing statement or a letter of transfer from your bank. If you leave this section entirely blank, you will be declaring to HPD that your household has no assets.

**For a list of different asset sources see the "What is an Asset?" form below.**

FULL NAME	Description of Account or Asset Type / Account Number (if Any)	AMOUNT	ANTICIPATED INCOME (e.g., interest)

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**REAL ESTATE PROPERTY**

Households must report the ownership of any real estate property at every recertification. Please list all properties to which a family has ownership interest and complete the Real Estate Declaration form which can be found at (<https://www.nyc.gov/site/hpd/services-and-information/section-8.page>).

Is any property a Cooperative (Co-op)?	Yes	No
Do you collect rent from this property?	Yes	No
Is any of the property you own your primary residence?	Yes	No

NAME(S) OF PROPERTY OWNER(S)	ADDRESS OF PROPERTY	PROPERTY VALUE	ANTICIPATED INCOME (e.g. rental income)

**IF YOU HAVE SOLD OR DISCARDED PROPERTY SINCE ADMISSION TO THE PROGRAM OR YOUR LAST CERTIFICATION, COMPLETE THE SECTION BELOW: INCOME FROM SALE**

NAME(S) OF PROPERTY OWNER(S)	PROPERTY ADDRESS	SALE PRICE	PROFIT EARNED





Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**MEDICAL EXPENSES**

If the Head of Household or spouse is 62 years of age or older or has a documented disability, you may declare current and expected un-reimbursed periodic and one-time medical expenses since your last annual recertification by filling out "Declaration of Un-reimbursed Medical and Pharmacy Expenses" (Form 6) and providing supporting documentation including proof of payment. Please fill out this form even if your expenses have not changed. Please list below any qualified medical expenses and provide HPD with supporting documentation.

FULL NAME OF FAMILY MEMBER	DESCRIPTION OF EXPENSES	ANNUAL AMOUNT

**DISABILITY EXPENSES**

If you or a household member has a documented disability, you may declare current and expected un-reimbursed periodic and one-time disability expenses since your last annual recertification by filing out the "Declaration of Un-reimbursed Disability Expenses" (Form 7). Please fill out this form even if your expenses have not changed. Please list below any qualified disability expenses and provide HPD with supporting documentation.

FULL NAME OF FAMILY MEMBER	DESCRIPTION OF EXPENSES	ANNUAL AMOUNT



HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**CHILDCARE EXPENSES**

If you have current and expected un-reimbursed periodic or one-time childcare expenses since your last annual recertification, please refer to "Verification of Childcare Expenses" on (Form 9) to see if you qualify for this deduction. Please fill out this form even if your expenses have not changed. Please list below any qualified childcare and provide HPD with supporting documentation.

CHILD'S FULL NAME	ANNUAL AMOUNT

**UTILITY ALLOWANCE**

Utility allowance must be verified at every recertification. If any of the information below is incorrect, please provide HPD with a utility bill.

UTILITY	PAID BY OWNER (yes or no)	PAID BY TENANT (yes or no)
Gas		
Electric		
Heat and hot water		

Has any adult household member been registered as a lifetime sex offender since Rental Subsidy Housing assistance at HPD began? **Yes** **No**

If Yes, it is required that you list the name of the household member: \_\_\_\_\_





Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 1. AUTHORIZATION FOR THE RELEASE OF INFORMATION / PRIVACY ACT NOTICE**

**The Head of Household and all family members 18 years of age or older must sign a consent form** according to federal law (42 U.S.C. § 3544) and U.S. Department of Housing and Urban Development (HUD) regulation (24 CFR § 5.230). Failure to sign this consent form may result in denial of household's eligibility and/or termination of household's subsidy.

This consent authorizes HUD and HPD to obtain information directly from third party sources in order to verify the income, the value of assets, expenses related to deductions from income (including medical, pharmaceutical and day care expenses), family composition information, and related information for each household member. HUD and HPD will use the information received for the purposes of determining whether your family is eligible for Rental Subsidy benefits and to ensure that these benefits are set at the correct level.

**EACH HOUSEHOLD MEMBER 18 YEARS OF AGE OR OLDER MUST COMPLETE AND SIGN THIS FORM.**

**In order to complete or verify an application for participation and to maintain continued assistance in the Rental Subsidy program, this consent form authorizes the release of information necessary to permit HUD and HPD to obtain:**

1. Information from SWICAs (State Wage Information Collection Agencies, such as a Labor Department)
2. Salary and wage income information from previous or current employers and unearned income information (such as interest and dividend payments) from banks or other financial institutions
3. Information such as but not limited to:
  - Income from public or private pension funds, unemployment compensation, worker's compensation income, disability payments, military pay, alimony, child support, and private contributions; information related to school attendance verification and the receipt of financial grants from entities, credit agencies, or government agencies, including but not limited to the:
  - NYC Human Resources Administration, NYC Office of Payroll Administration, NYC Department of Finance, NYC Department of Health and Mental Hygiene, NYC Clerk's Office, NYS Department of Motor Vehicles, Courts and NYS Office of Court Administration, NYS Department of Labor, and U.S. Department of Veterans Affairs
4. Information from the Social Security Administration (SSA) for the purpose of verifying Social Security numbers and income information
5. Tax return information from the Internal Revenue Service (IRS)

**The authorization to release information specified by this consent form expires 15 months after the date that the form is signed. Photocopies of this consent form shall be as valid as the original.**

**CONSENT:** I consent to allow HUD and HPD to request and to obtain income information from the sources listed on this form for the purpose of verifying my eligibility and determining my level of benefits under HUD's assisted housing programs. I understand that HPD will not use information obtained by this consent to deny, reduce, or terminate assistance without first independently verifying the accuracy of this information. In addition, I must be given an opportunity to contest those determinations.

PRINT NAMES OF ALL FAMILY MEMBERS AGE 18 OR OLDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SIGNATURE	DATE
_____				
_____				
_____				

**PRIVACY ACT NOTICE:** Authority: HUD is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security number of each household member. Purpose: Your income and other information collected by HUD and HPD is used to determine your eligibility for Rental Subsidy assistance, the appropriate bedroom size of your voucher, and the amount that your family will pay toward rent and utilities. Other Uses: HPD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate federal, state, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD or HPD, except as permitted or required by law. Penalty: You must provide all of the information requested by HPD, including all Social Security numbers that you and all other household members ages six years or older have and use. Providing the Social Security numbers of all household members is mandatory, and not providing the Social Security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.



Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 2. REQUEST TO ADD A HOUSEHOLD MEMBER**

Complete this form to declare any additions to your household by birth, adoption, marriage, or domestic partnership or if you would like to request that any other individuals be added to your household. All proposed additions to household age 18 and over will be screened for criminal background and sex offender registration.  <b>TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD AND PROPOSED MEMBER</b>	<b>Have you completed this form?</b>	
	<b>Yes</b> <input type="checkbox"/>	<b>Not Applicable</b> <input type="checkbox"/>

- Required for all proposed household members **18 years of age and older**:
- A photo ID, Social Security card, birth certificate, and proof of most recent address.
- A signed "Authorization for the Release of Information" (Form 1).
- Documentation of any income received by the proposed household member required for all proposed household members **under 18 years of age**.
- Custody documents or a letter from a social service provider stating the child permanently resides with the head of household.
- A copy of Social Security card and birth certificate.
- Proof of child support payments (if the new household member receives child support).

LAST NAME	FIRST NAME	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER
_____ / _____ / _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No BIRTH DATE			
<b>Are you employed</b> Yes No. If "Yes", please complete "Verification of Wages" (Form 4). All earned and unearned income must be documented. Please see "What is Income?" section.			
Declaration of Citizenship Status <input type="checkbox"/> Citizen Non-citizen with Eligible Immigration Status Non-citizen who chooses not to declare Eligible Immigration Status			
<b>If your status is "Citizen" you must provide documentation if "Non-citizen with Eligible Immigration Status," you must include one of the following documents:</b> 1) Alien Registration Card (Form I-551), 2) Arrival Departure Record (I-94), 3) Temporary Resident Card (I-688), or Employment Authorization Card (I-688B). <b>If "non-citizen who chooses not to declare" household subsidy will be based on the number of eligible citizens and legal residents in the household.</b>			

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law and may result in loss of subsidy.

_____ SIGNATURE OF PROPOSED HOUSEHOLD MEMBER OR GUARDIAN (IF UNDER 18)	_____ DATE
_____ SIGNATURE OF HEAD OF HOUSEHOLD	_____ DATE





Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 3. REQUEST TO REMOVE A HOUSEHOLD MEMBER**

<p>To request that any individual be removed from the Section 8 household composition, please complete this form and provide documentation of the departing member's new address (example: copy of the departed/departing member's new lease or utility bill). If household member has died, please provide date of death or a copy of the death certificate.</p> <p style="text-align: center;"><b>TO BE COMPLETED BY HEAD OF HOUSEHOLD</b></p>	<b>Have you completed this form?</b>	
	<b>Yes</b> <input type="checkbox"/>	<b>Not Applicable</b> <input type="checkbox"/>

Name of person to remove from Section 8 household composition:

Last Name	First Name	Social Security Number
-----------	------------	------------------------

**I have included the following to remove the above family member from my household:**

- Lease or utility bill from the departing/departed household member's new address\*, OR
- Copy of the death certificate, OR
- Date of Death \_\_\_\_\_ (HPD will verify with the Social Security Administration)

\*If a copy of the lease or bill is not available, please explain why:

**\*\*Head of Household Must Sign and Date Below\*\***

I, the Head of Household, certify that the information given to HPD on the date of \_\_\_\_\_ is accurate and complete to the best of my knowledge and belief. I understand that false statements or information are punishable by federal law and may result in the termination of my housing assistance. I further understand that HPD may verify my income or other relevant information with a third party, such as the Enterprise Income Verification (EIV) database.

<hr style="border: 0; border-top: 1px solid black;"/> <b>SIGNATURE OF HEAD OF HOUSEHOLD</b>	<hr style="border: 0; border-top: 1px solid black;"/> <b>DATE</b>
---	---

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**What is Income?**

<p>The Head of Household must complete the form on the following page for each member of the household who receives any income and provide documentation. Please first review the definitions and examples of income listed below and see if they apply to any member of the household.</p> <p style="text-align: center;"><b>TO BE COMPLETED AND SIGNED BY HEAD OF HOUSEHOLD.</b></p>	<b>Have you completed this form?</b>	
	<b>Yes</b> <input type="checkbox"/>	<b>Not Applicable</b> <input type="checkbox"/>

**INCOME SOURCES**

- Employment: Please indicate the amount you or a household member receives from employment. Provide two recent consecutive paystubs or a verification letter on letter head from your employer stating amount and frequency of pay. You may also have "Form 4. Verification of Wages" completed by your employer.
- Social Security /SSI: Please indicate the amount you or a household member currently receives. HPD will verify this information using HUD's Enterprise Income Verification (EIV) database.
- Public Assistance: Provide a verification letter which states the amount of benefits paid.
- Child Support / Alimony: Provide official documentation or a letter from any parent(s) of minors living in the assisted household without one or both parents, showing the frequency and amount of child support and/or alimony payments. Provide an official document or copy of any legal separation documents. If there is no legal document, provide a letter from the person providing child support stating the amount and frequency of child support provided if any. A child will only be considered part of the household if he or she resides in the household at least 183 days (over 6 months / 50%) of the year.
- Disability: Provide official documentation of frequency and amount of disability payments.
- Unemployment /Worker's Compensation: Provide official documentation of the frequency and amount of unemployment and/or worker's compensation payments.
- Pension / Retirement: This category includes IRA distributions that must be reported. Provide official documentation of the frequency and amount of pension/ retirement income.
- Veteran's Pay: Provide official documentation of the frequency and amount of income from Veteran's Pay
- Financial Aid/ Scholarship: Provide official documentation from the source of the educational financial aid/ scholarship with the amount and frequency of money received.
- Real Estate: Please provide documentation of any income you receive from owning real property (e.g., rental income, income earned from the sale of property, etc.)
- Self-employment / Seasonal employment: If you are self-employed, a seasonal employee, a freelance worker (like delivery or taxi driver using a ride-share mobile phone application), or have had more than one employer in the past 12 months, provide a complete signed copy of your most recent tax return.
- Other Types of Support: If a household member receives any regular income from organizations or persons (including relatives and friends) not residing in your home, provide documentation of such support. For example, a signed statement from the person or agency providing the income, verifying the amount and frequency.



Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 4. VERIFICATION OF WAGES**

<p>The purpose of this form is to verify the wages of each household member. Each employed household member <b>must</b> complete this form if the below are not available:</p> <ul style="list-style-type: none"> <li>Two (2) recent consecutive pay stubs stating gross wages</li> <li>Letter from employer stating gross wages and work hours</li> </ul> <p><b>SECTION A TO BE COMPLETED BY EMPLOYED HOUSEHOLD MEMBER</b>  <b>SECTION B TO BE COMPLETED, STAMPED AND SIGNED BY CURRENT EMPLOYER</b></p>	<p><b>Have you completed this form?</b></p>	
	<p>Yes</p> <input type="checkbox"/>	<p>Not Applicable</p> <input type="checkbox"/>

**SECTION A (to be completed by EMPLOYEE)**

Name of Employee: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B (to be completed by EMPLOYER)**

Company: \_\_\_\_\_ Address: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

Type of Income	Amount	Pay Frequency (Hourly, Bi-weekly, Monthly, Annual) Write in Below	Average hours worked per pay period
Current gross wages:	\$		
Gross wages in the past 12 months	\$		
Overtime:	\$		
Bonus, commission, or tips:	\$		
Armed Forces wages for exposure to hostile fire:	\$		
Future gross wages: (If wages are expected to increase, please indicate date effective: ___/___/___)	\$		

If wages for employee are seasonal, sporadic, or cannot be accurately captured in the above chart, please explain: \_\_\_\_\_

Original hire or rehire date: \_\_\_\_\_ Date of termination: \_\_\_\_\_

**COMPANY STAMP/SEAL IS MANDATORY**

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law.

\_\_\_\_\_

SIGNATURE OF OFFICIAL DATE

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (Last 4 digits)
------------------------	---

**WHAT IS AN ASSET?**

An asset is something you own that you can convert into cash, such as bank accounts, real estate, stocks and bonds. If you or any household member, including children, owns any of the types of assets listed below, you must declare them in the Rental Subsidy Participating Household Summary page of this recertification package. Additionally, you must submit documents verifying the value of the asset(s) and income earned from the asset if applicable. Failure to report assets may result in termination or denial of subsidy. Below is a list of different types of assets and their descriptions.

**TO BE REVIEWED BY HEAD OF HOUSEHOLD**

**ASSET SOURCES**

- Bank Accounts: Any account that is open with any balance at any bank whether individually or jointly owned. Examples are checking, saving, money market accounts, and certificates of deposit. Provide a verification letter on letterhead from your financial institution, provide the most recent bank statement, or have a Form 5. Verification of Assets form completed by the financial institution.
- Online Financial Accounts: Any account that is online, that is not a bank, and where you deposit cash. These can be online money transfer accounts or online wallets where you keep cash.
- Investment Accounts: Examples of investments accounts are stocks and bonds. Provide official documentation stating the value and any dividends earned on the account or the most recent statement from the financial institution.
- Equity in Real Estate Property: Equity in real property is the estimated market value of any property owned less the unpaid balance on loans secured by the asset. Provide property tax statements and mortgage statements if applicable.
- Retirement Savings Accounts: A formal account that enables you to set aside money to be spent after retirement. Examples of this type of account include, IRA, Keogh and 401K plans. Provide official documentation stating the value and any dividends earned on the account or the most recent statement from the financial institution.
- Company Retirement or Pension Accounts: (If any member of the family has access) Provide official documentation of frequency and amount of payments.
- Lump sum payment: A one time payment that is retained and can be verified. Examples of lump sum payments are Inheritances, insurance payments, or settlements. Provide official documentation of the value of the payment and any interest income earned.
- Personal property held as investment: Any object or collection of value that can be converted into cash. Examples of this include coin collection, recreational vehicles, jewelry etc. Provide official documentation of the value of the property and any outstanding debt.
- Additional examples of assets: Examples of additional types of assets include cash value of life insurance, cash value of trusts, Annuities, S corporations, partnerships and time shares. Documentation verifying the value of these assets must be provided.

**THE FOLLOWING ARE NOT ASSETS: DO NOT add** Electronic Benefits Transfer (EBT) accounts, or similar accounts used for receiving government benefits (such as SNAP and WIC). These are not assets.

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 5. VERIFICATION OF BANK ACCOUNTS AND OTHER ASSETS**

<p>The purpose of this form is to provide third party verification of each household member's assets. Assets are items of value that may be turned into cash and may include savings accounts, checking accounts, IRA accounts, Certificates of Deposit (CDs), stocks/bonds, and online financial accounts. Each household member must provide bank statements or other evidence of assets provided by the financial institution. If these statements are not available, each member must have their financial institution complete this form.</p> <ul style="list-style-type: none"> <li>If an asset holder has unverified assets from more than one financial institution, a separate form should be used for each financial institution.</li> <li>If assets reported on this form are joint assets, one form may be submitted for the joint asset holders.</li> </ul> <p><b>SECTION A TO BE COMPLETED BY HEAD OF HOUSEHOLD, AND RETURNED IF NO MEMBER OF THE HOUSEHOLD HAS ASSETS</b></p> <p><b>SECTION B TO BE COMPLETED, STAMPED AND SIGNED BY FINANCIAL INSTITUTION FOR EVERY MEMBER OF THE HOUSEHOLD WITH ASSETS</b></p>	<p><b>Have you completed this form?</b></p>
	<p><b>Yes</b>  <input type="checkbox"/></p> <p><b>Not Applicable- (Complete Section A)</b>  <input type="checkbox"/></p>

**SECTION A (To be completed and returned by Head of Household, if applicable)**  
 I certify that no one in my household has a savings account, checking account, IRA, CD or stocks/bonds.  
 Signature (Head of Household): \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION B (To be completed by financial institution for each household member with assets)**  
 Name of Asset Holder \_\_\_\_\_ Social Security Number \_\_\_\_\_

Type of Asset (savings, checking or retirement account, stocks, CDs, etc.)	Account Number	Current Balance	Early Withdrawal Fees or Penalties (if any)	Current Rate of Interest/ Number of Shares	Is This a Joint Account/Asset?	
					Yes/ No	Joint Asset Holder's Name

Financial Institution: \_\_\_\_\_ Address \_\_\_\_\_  
 Representative: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

**COMPANY STAMP/SEAL IS MANDATORY**

I certify that the above information is true and correct as of \_\_\_\_\_ (date). I understand that providing false statements to a government agency is punishable under federal law.

\_\_\_\_\_  
**SIGNATURE OF OFFICIAL**

\_\_\_\_\_  
**DATE**

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 6. DECLARATION OF UN-REIMBURSED MEDICAL & PHARMACY EXPENSES**

<p><b>If the Head of Household, co-head, or spouse is disabled, and/or 62 years of age or older</b> and has <b>un-reimbursed</b> (not already paid for by someone other than yourself) medical or pharmacy expenses, please complete this form for each household member with medical or pharmacy expenses. You must submit verification of all un-reimbursed medical and pharmacy expenses incurred during the last 12 months if they are expected to be an expense in the upcoming year. This includes copies of cancelled checks, receipts, or statements from an insurance company. Please submit a pharmacy printout for any un-reimbursed prescription payments you have made in the past 12 months.</p> <p><b>TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD</b></p>	<p><b>Have you completed this form?</b></p>	
	<p><b>Yes</b></p> <p><input type="checkbox"/></p>	<p><b>Not Applicable</b></p> <p><input type="checkbox"/></p>

**Is Your Household Eligible for a Medical Expense Deduction?**

- Do you have any un-reimbursed pharmacy expenses?  Yes  No
- Do you pay a Medicare premium or pay for medical insurance?  Yes  No
- Is any family member currently paying off past medical bills?  Yes  No
- Is there an anticipated medical expense during the next 12 months?  Yes  No

**If you answered yes to any of the questions above, please complete the box below:**

Name of Household Member	Eligible Expense (pharmacy, insurance premiums, dental, hearing aid, eyeglasses, medical equipment)	Amount Due, Paid in the Past, or Expected in the Next 12 Months* (Submit proof of payment or invoice)	Expense Date or Payment Frequency (monthly, annually, etc.)	Name and Phone Number of Institution Providing Service

\*If copies of cancelled checks, receipts, or statements from an insurance company are not available, you may submit a statement from your doctor, pharmacist, or other medical-related service provider specifying the nature and amount of expenses expected in the next 12 months. Only the portion of the total medical expense that exceeds 3% of the household annual income is an allowable deduction.

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law and may result in loss of subsidy.

\_\_\_\_\_

**SIGNATURE OF HEAD OF HOUSEHOLD** **DATE**

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 7. DECLARATION OF UN-REIMBURSED DISABILITY EXPENSES**

<p>If your family has an un-reimbursed expense for attendant care (home health aid for a disabled adult or baby-sitter for a disabled child age 13 or older) or medical equipment (such as a wheelchair) <b>for a household member who is disabled</b> and as a result of this expense, you or any household member were able to earn income from a job, you should complete this form. You must submit verification of any disability expenses incurred during the last 12 months. This may include a receipt for a wheelchair, ramp, adaptation to a vehicle, or special equipment to enable a blind person to read and write.</p> <p><b>TO BE COMPLETED AND SIGNED BY THE HEAD OF HOUSEHOLD</b></p>	<p><b>Have you completed this form?</b></p>	
	<p><b>Yes</b></p> <input type="checkbox"/>	<p><b>Not Applicable</b></p> <input type="checkbox"/>

**Is Your Household Eligible for a Disability Expense Deduction?**

- Do you pay for someone to care for a disabled person in your household?  Yes  No
- Did you buy medical equipment for a disabled person in your household?  Yes  No
- Were you or any another household member able to earn income from a job because of this disability expense?  Yes  No

If you answered yes to question #3 above, please complete the boxes below:

	Name of disabled household member:	Name of disabled household member:
	1. _____	2. _____
<b>Eligible disability expense(s):</b> (medical equipment or attendant care expense)		
<b>Amount due or expected in the next 12 months:</b> (Submit proof of recurring payments or invoice)		
<b>Name(s) and phone number of institution(s) providing service:</b>		
<b>Name(s) of household member(s) who earned income as a result of the disability expense:</b>		

Note: Only the portion of the total disability expense that exceeds 3% of your household annual income is an allowable deduction. The deduction for the disability expense may not exceed the total amount of money earned by the household member(s) who are able to work because of the disability expense.

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law and may result in loss of subsidy.

---

SIGNATURE OF HEAD OF HOUSEHOLD DATE

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 8. VERIFICATION OF STUDENT STATUS**

<p>The purpose of this form is to verify student status. Each household member 18 years of age or older who attends school full-time or is in a job training program <b>must</b> complete this form. If this form cannot be completed, please provide one of the following to verify student status:</p> <ul style="list-style-type: none"> <li>• High school students may submit their most recent report card or a letter from a school official confirming enrollment</li> <li>• College students may submit their most recent transcript or a letter from an official at their college</li> <li>• Students in adult training programs may submit enrollment documents or a letter from a program official</li> </ul> <p><b>THIS FORM MUST BE COMPLETED, STAMPED AND SIGNED BY A SCHOOL/JOB TRAINING PROGRAM ADMINISTRATOR.</b></p>	<p><b>Have you completed this form?</b></p>	
	<p><b>Yes</b>  <input type="checkbox"/></p>	<p><b>Not Applicable</b>  <input type="checkbox"/></p>

**SECTION A (to be completed by Head of Household)**

Student Household Member: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B (to be completed by School or Job Training Program Administrator)**

1. The student named above is enrolled in:  High School/College  Adult Training Program

*If you selected "High School/College," skip #2 and go to #3.*

2. Is the program providing employment training and self-sufficiency services?  Yes  No

Is the program funded by the federal, state, or local government?  Yes  No

Is the program funded by HUD?  Yes  No

3. Enrollment Status:

This student is enrolled in a (check one) **full time/ part time** program and will earn \_\_\_\_\_ credits this semester. Weekly hours of program participation if in an adult training program: \_\_\_\_\_

	Amount per year
Tuition	
Work Study	
Grants/Scholarship	

Educational Institution: \_\_\_\_\_ Address \_\_\_\_\_

Administrator: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

**COMPANY STAMP/SEAL IS MANDATORY**

--

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law.

\_\_\_\_\_  
 SIGNATURE OF ADMINISTRATOR

\_\_\_\_\_  
 DATE



HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 9. VERIFICATION OF CHILDCARE EXPENSES**

Households who have un-reimbursed childcare expenses should complete this form if: <input type="radio"/> The expenses are for a child or children age 12* or younger <u>and</u> <input type="radio"/> The childcare is necessary for a family member to be gainfully employed or to further his or her education.  <b>THIS FORM MUST BE COMPLETED BY THE HEAD OF HOUSEHOLD AND COMPLETED AND SIGNED BY THE CHILDCARE PROVIDER.</b>	<b>Have you completed this form?</b>	
	Yes <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

Name of Child	Age of Child	Rate of Pay During School Year	Rate of Pay During School Vacations	Frequency of Pay (hourly, daily, weekly, monthly, annually)	Monthly Average
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$

If childcare expenses are seasonal, sporadic, or cannot be accurately captured in the above chart, please explain: \_\_\_\_\_

Name of Childcare Provider: \_\_\_\_\_ Address: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone (Required): \_\_\_\_\_

\*If child is 13 or older, disabled, and care for child enables an adult household member to be employed, please complete "Verification of Un-Reimbursed Disability Expenses" (Form 7).

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law.

\_\_\_\_\_  
 SIGNATURE OF CHILD CARE PROVIDER

\_\_\_\_\_  
 DATE

**FOR HPD USE ONLY**

Call to provider made on \_\_\_\_\_ (date) by \_\_\_\_\_ staff member's name

Expenses verified?  Yes  No Notes: \_\_\_\_\_





Division of Tenant Resources

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**FORM 10. DEBTS OWED TO PUBLIC HOUSING AGENCIES AND TERMINATIONS (Cont'd)**

**How will this information be used?**

PHAs will have access to this information during the time of application for rental assistance and reexamination of family income and composition for existing participants. PHAs will be able to access this information to determine a family's suitability for initial or continued rental assistance, and avoid providing limited Federal housing assistance to families who have previously been unable to comply with HUD program requirements. If the reported information is accurate, your current rental assistance may be terminated and your future request for HUD rental assistance may be denied for a period of up to ten years from the date you moved out of an assisted unit or were terminated from a HUD rental assistance program.

**What are my rights?**

In accordance with the Federal Privacy Act of 1974, as amended (5 USC 552a) and HUD regulations pertaining to its implementation of the Federal Privacy Act of 1974 (24 CFR Part 16), you have the following rights:

1. To have access to your records maintained by HUD.
2. To have an administrative review of HUD's initial denial of your request to have access to your records maintained by HUD.
3. To have incorrect information in your record corrected upon written request.
4. To file an appeal request of an initial adverse determination on correction or amendment of record request within 30 calendar days after the issuance of the written denial.
5. To have your record disclosed to a third party upon receipt of your written and signed request.

**What do I do if I dispute the debt or termination information reported about me?**

You should contact the PHA, who has reported this information about you, in writing, if you disagree with the reported information. The PHA's name, address, and telephone numbers are listed on the Debts Owed and Termination Report. You have a right to request and obtain a copy of this report from the PHA. Inform the PHA why you dispute the information and provide any documentation that supports your dispute. Disputes must be made within three years from the end of participation date. Otherwise the debt and termination information is presumed correct. Only the PHA who reported the adverse information about you can delete or correct your record.

Your filing of bankruptcy will not result in the removal of debt owed or termination information from HUD's EIV system. However, if you have included this debt in your bankruptcy filing and/or this debt has been discharged by the bankruptcy court, your record will be updated to include the bankruptcy indicator, when you provide the PHA with documentation of your bankruptcy status.

The PHA will notify you in writing of its action regarding your dispute within 30 days of receiving your written dispute. If the PHA determines that the disputed information is incorrect, the PHA will update or delete the record. If the PHA determines that the disputed information is correct, the PHA will provide an explanation as to why the information is correct.

**This Notice was provided by the New York City Department of Housing Preservation and Development  
I hereby acknowledge that the PHA provided me with the *Debts Owed to PHAs & Termination Notice*:**

PRINT NAMES OF ALL FAMILY MEMBERS AGE 18 OR OLDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SIGNATURE	DATE

OMB No. 2577-0266 Expires 04/30/2013 April 26, 2010 Alternative to Form HUD-52675

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**RECERTIFICATION PACKAGE CHECKLIST**

Please carefully read the instructions for this Recertification Package. This checklist and the instructions will tell you what forms are required in order to continue receiving Rental Subsidy rental assistance. In addition to the cover page and Rental Subsidy Participant Household Summary, **there are ten (10) forms in the Recertification Package.** Please check the last column of this checklist as you complete each form. If a form does not apply to your household, you must check "N/A" on the checklist, and the form, and return both the checklist and the form with your package.

**TO BE COMPLETED BY THE HEAD OF HOUSEHOLD.**

**Have you completed this form?**

Yes

Form #	Form Name	Who Must Complete this Form	Completed?
<b>Cover Page</b>	Rental Subsidy Recertification Package Cover Page	The Head of Household must sign the cover page to certify that the package has been filled out truthfully and completely.	<input type="checkbox"/> Yes
<b>Participant Household Summary</b>	Rental Subsidy Participant Household Summary	The Head of Household must review and make corrections to information that was reported at the last annual certification.	<input type="checkbox"/> Yes
<b>1</b>	Authorization for the Release of Information/ Privacy Act Notice	Each member of the household age 18 years and older must sign <b><u>and date</u></b> this form.	<input type="checkbox"/> Yes
<b>2</b>	Request to Add a Household Member	Households that would like to request to add a person to their Rental Subsidy household must complete this form and submit the documents requested.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
<b>3</b>	Request to Remove a Household Member	Households that would like to request to remove a person to their Rental Subsidy household must complete this form and submit the documents requested.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
<b>4</b>	Verification of Wages	Each employed member must provide two (2) recent consecutive paystubs <b><u>OR</u></b> have his or her employer complete this form <b><u>OR</u></b> provide a letter from the employer stating employment dates and income.	<input type="checkbox"/> Yes, given to employer <input type="checkbox"/> N/A
<b>5</b>	Verification of Bank Accounts and other Assets	<p>Each household member who owns assets must have his or her financial institution complete this form. Assets include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Savings accounts</li> <li>▪ Checking accounts</li> <li>▪ IRAs, CDs or bonds</li> <li>▪ Real estate</li> <li>▪ Stocks/bonds</li> </ul> <p>Recent financial statements from the institution or bank may be submitted as an alternative.</p>	<input type="checkbox"/> Yes, given to financial institution <input type="checkbox"/> Yes, documentation enclosed <input type="checkbox"/> N/A



HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**RECERTIFICATION PACKAGE CHECKLIST *CONTINUED***

Form #	Form Name	Who Must Complete this Form	Form Completed
6	Declaration of Un-Reimbursed Medical and Pharmacy Expenses	<p>You may complete this form if the Head of your Household, spouse or co-head are:</p> <ul style="list-style-type: none"> <li>▪ Legally disabled</li> <li>▪ 62 years of age or older</li> </ul> <p>This form may be completed to deduct <b>un-reimbursed</b> medical, pharmacy, or disability expenses expected in the next 12 months. Only the portion of the total medical expense that exceeds 3% of the household annual income is an allowable deduction.</p> <p>This form is not complete without documentation of these expenses.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
7	Declaration of Un-Reimbursed Disability Expenses	<p>If your family has an <u>un-reimbursed expense for attendant care</u> (home health aid for a disabled adult or baby-sitter for a disabled child age 13 or older) <u>or medical equipment</u> (such as a wheelchair) <b>for a household member who is disabled</b> and as a result of this expense, you or any household member (including the disabled person) were able to earn income from a job, you should complete this form.</p> <p>This form is not complete without documentation of these expenses.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
8	Verification of Student Status	Each household member who is 18 years of age or older who attends school full-time, or who is in a job training program, must have this form completed by the educational institution.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
9	Verification of Childcare Expenses	This form only applies if child care expenses are for the care of children 12 years old or younger, and only if child care is necessary for a family member to be employed, to further his or her education, or to seek employment.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
10	Debts Owed to Public Housing Agencies and Terminations	Each adult household member must sign this form which explains your rights regarding household information HPD is required to collect. <b>Any household member who has turned 18 years of age since the last recertification must sign this form.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> N/A



HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
------------------------	--

**LANGUAGE ASSISTANCE FORM**

- Spanish / Español

Si usted desea ayuda en algún idioma para completar este paquete, por favor llame al 917-286-4300. Un representante HPD podrá ayudarlo a obtener ayuda. Por favor marque el casillero al final de esta declaración si es que a usted le gustaría que registremos la preferencia de idioma marcada para referencia futura.

- French / Français

Si vous désirez obtenir de l'aide dans votre langue pour remplir ce document, veuillez appeler le 917-286-4300. Un représentant du service des logements pourra vous aider à obtenir de l'aide. Veuillez cocher la case à la fin de cet énoncé si vous désirez que nous notions votre préférence de langue indiquée pour référence future.

- Haitian Creole / Kreyòl ayisyen

Si w ta renmen jwenn asistans pou ranpli pake sa a, tanpri rele 917-286-4300. Yon anplwaye HPD ap kapab ba ou bon jan asistans. Tanpri tcheke kaz ki nan fen fraz sa a si w ta renmen nou endike lang ou pi pito pou referans alavni.

- Russian / Русский

Если вам нужна помощь переводчика при заполнении этих анкет, звоните по телефону 917-286-4300. Представитель отдела HPD поможет вам вызвать переводчика. Пометьте соответствующий язык ниже, если вы хотите пользоваться этой услугой и в будущем.

- Cantonese / 廣東話

如果您在填寫這套表格時需要以廣東話提供協助，請致電917-286-4300。  
 一位HPD代表將可協助您獲得幫助。如果您希望我們記錄指明的語言選擇供未來參考之用，請在本聲明結尾處剔選相關的方格。

- Chinese Mandarin / 普通话

如果您在填写这套表格时需要以普通话提供协助，请拨打917-286-4300。  
 一位HPD代表将可协助您获得帮助。如果您希望我们记录指明的语言选择供未来参考之用，请在本声明结尾处剔选相关的方格。

- Arabic / العربية

وراء الفون لفين ذلي وذن نمون نويد، عقود م او نه ث 4300-286-917. زنت اي عيبن، ة زلي ه ع د ل ف يوغ ة صمبي لذيت نك اذا يتنوغ عتك اذا ة از العن. لي ه ل لبة ي از عنيب عظ ع ز اي، اع عتول ة صمبي لذ ل م ك ة اعوم، عن HPD علس ل لدن لوي ا قيق سوم، ن دلي، د د ا ر ي ض ز ع ك د ف

- Other \_\_\_\_\_

If you would like assistance in a different language, please check the box indicating your preference. For assistance in completing this package, please call 917-286-4300