Human Resources Administration
Department of Social Services

HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER (last 4 digits) Head of Household

FORM 7: REMOVAL OF A HOUSEHOLD MEMBER

If any individual left or is about to leave your household, please complete this form and provide documentation of the departed/departing member's new address. If a household member has died, please provide a copy of the death certificate (if available) or the date of death.

You must also complete this form for any household member who is absent from the assisted unit for more than 90 consecutive days (other than a child residing in the assisted unit with his or her parent for at least 183 days per year pursuant to a joint custody agreement or order, a foster child placed and residing in the assisted unit for more than 183 days of the year, or a household member away at school who intends to live with the household in the assisted unit during school recesses). An individual who is absent from the assisted unit for more than 90 consecutive days will not be counted as a household member unless such individual is absent due to hospitalization, military deployment, or other good cause as determined by HRA and is reasonably expected to return within 180 days.

TO BE COMPLETED BY HEAD OF HOUSEHOLD

Name of departed/departing, deceased, or absent household member:

_____	_____	_____
First Name	**Last Name**	**Social Security Number**

I have included the following to document that the person named above is no longer a member of 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 _____ (HRA will verify with the Social Security Administration)

*If a copy of the lease or bill is not available, please explain why and provide new address or contact information (if known):

_____

_____

Complete the following if the household member is absent from the assisted unit for more than 90 consecutive days but is expected to return within 180 days. The person named above is absent due to:

- o Hospitalization
- o Military deployment
- o Other reason (specify) _____

You must provide verification from the hospital, military, or other sources.

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 HRA HOME TBRA benefits.

_____	_____/_____/_____
SIGNATURE OF HEAD OF HOUSEHOLD	**DATE**