

# South Shore Housing

169 Summer Street

Kingston, MA 02364-1220

(781) 422-4200; 1-800-242-0957

FAX (781) 585-7483 TDD (781) 422-4200

## ANNUAL RECERTIFICATION PAPERWORK

If you receive EAEDC, TAFDC or FOOD STAMP please contact the DTA Office at 1-800-632-8095 to request a printout of benefits. Submit to SSH as soon as you receive it.

If any household member has WAGES please submit 6 consecutive pay stubs and complete the enclosed Income Verification Form. *Please note that South Shore Housing now has the ability to match income of all household members via HUD's Enterprise Income Verification System.*

If any household members receive Social Security or Supplemental Security Income please provide us with documentation of your benefit amounts. This may be in the form of an SSA benefit letter, SSA award letter or another letter from SSA showing the benefit amount. You may call (800) 772-1213 to obtain a current printout of your benefit information.

If any household member receives a PENSION, UNEMPLOYMENT or VA BENEFITS please submit a copy of the most recent pay stub and complete the enclosed Income Verification Form.

If you receive CHILD SUPPORT or ALIMONY please supply a copy of the current court order or contact DOR at 1(800) 332-2733 to receive a 12 month printout of payments received.

For all household ASSETS please submit your most current bank statement and complete an Asset Verification Form. If you have non-cash assets, please notify us as to what they are.

If any household member over 18 years old is a Full-time Student you may be eligible for a deduction. You must obtain a letter from the school stating they attend full-time.

If you are elderly, disabled, and/or handicapped, or a participant of the Massachusetts Rental Voucher Program (MRVP), please send verification of paid out of pocket medical expenses.

If you pay for childcare in order to work or attend school please provide verification of your weekly daycare costs or complete the enclosed Day Care Form.

Do not wait to obtain all of your verifications to send in enclosed packet.

We will not accept faxed renewal packets.

**SSHDC SECTION 8/MRVP FAMILY CERTIFICATION FORM**

ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

PHONE #'S: HOME: ( ) WORK : ( ) EMAIL: \_\_\_\_\_

**FAMILY COMPOSITION (PLEASE USE OTHER SIDE IF YOU NEED MORE SPACE)**

FAMILY MEMBER	NAME: LAST, FIRST, MIDDLE	DATE OF BIRTH	*RACE/ETHNICITY	SEX M/F	SOCIAL SECURITY NO.	LAST GRADE
HEAD			/			
1.			/			
2.			/			
3.			/			
4.			/			
5.			/			
6.			/			
7.			/			

RACE CODES ARE: 1=WHITE 2=BLACK 3=American Indian 4=ASIAN/PACIFIC ISLANDER, ETHNICITY CODES ARE 1=HISPANIC OR 2=NOT HISPANIC. PLEASE USE BOTH CODES (ONE EACH SIDE OF THE SLASH) FOR EACH MEMBER. EXAMPLE: 2/2= BLACK/NOT HISPANIC.

**INCOME:** FAILURE TO REPORT ALL INCOME FROM ALL SOURCES FOR ALL FAMILY MEMBERS IS GROUNDS FOR TERMINATION OF RENTAL ASSISTANCE.

FAMILY MEMBER	SOURCE OF INCOME:	WEEKLY AMOUNT	ACCOUNT NUMBER	BANK NAME	VALUE
HEAD					
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**HEAD OR SPOUSE 62 YEARS OR OLDER, OR ANY AGE DISABLED,** ELIGIBLE FOR SELF-PAID MEDICAL EXPENSES IN EXCESS OF 3% OF GROSS ANNUAL INCOME? YES \_\_\_\_\_ NO \_\_\_\_\_

**IF YOU WORK OR ATTEND SCHOOL,** DO YOU PAY FOR CHILDCARE FOR CHILDREN 12 YEARS OR YOUNGER? YES \_\_\_ NO \_\_\_ \$ \_\_\_\_\_ PER WEEK

**INDICATE THE FOLLOWING BENEFITS YOU RECEIVE:** MEDICAID/CHILDRENS HEALTH INSURANCE PROGRAM \_\_\_\_\_ EARNED INCOME CREDIT \_\_\_\_\_ FOOD STAMPS \_\_\_\_\_

**WORK RELATED BENEFITS:** HEALTH INSURANCE \_\_\_ RETIREMENT PLAN \_\_\_ OTHER \_\_\_\_\_

I HEREBY CERTIFY THAT THE ABOVE INFORMATION ON FAMILY COMPOSITION, GROSS ANNUAL FAMILY INCOME, NET ASSETS, AND ELIGIBILITY FOR DEDUCTIONS IS COMPLETE, TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF HEAD OF HOUSEHOLD \_\_\_\_\_ DATE \_\_\_\_\_

