Housing Authority of the Sac and Fox Nation
201 N. Harrison • P.O. Box 1252 • Shawnee, OK 74801 • Ph (800)831-7515 • (405)275-8200 • Fax (405)275-8203

2024 ANNUAL RECERTIFICATION FORM

Date: _____

PLEASE PROVIDE THE FOLLOWING DOCUMENTS

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

MAILING ADDRESS (IF DIFFERENT): _____

CITY/STATE: _____ ZIP CODE: _____

HOME PHONE: (___)_____ WORK PHONE: (___)_____

CELL PHONE: (___)_____ MESSAGE PHONE: (___)_____

NUMBER OF BEDROOMS: _____ NUMBER IN HOUSEHOLD: _____

E-MAIL ADDRESS: _____

HOUSEHOLD COMPOSITION

NAMES	RELATION TO HEAD	SEX	DATE OF BIRTH	EMPLOYED (YES/NO)	DISABLED (YES/NO)	S.S. NUMBER	TRIBE
	HEAD						

DO YOU OWN ANY PETS _____ Yes _____ No

ANNUAL HOUSEHOLD INCOME

Income verification must be included for all income of your household. Income verification **CANNOT** be check stubs, copies of checks or W-2 forms. A signed statement from your employer is needed.

TOTAL ANNUAL HOUSEHOLD INCOME: $ _____

*****If your household presently has zero income, please provide a statement from where you receive assistance in paying your regular monthly house/rent payment (this can be a note from a family member or other source of assistance). If you report zero income, you will be given (60) days to have income reported.**

DEDUCTIONS

1. Verification of **CHILD CARE EXPENSES**, if you list any on this application. **(A note needs to be provided from your child-care provider stating how many hours of child-care is provided and how much per hour is paid for each child).** Anticipated amount to be spent for the care of minors under the age of thirteen (13) or disabled/handicapped family members $_____ *PROOF MUST BE PROVIDED FROM DAYCARE*

2. Verification of **HANDICAP OR DISABILITY**, if you list any on this application. **(A statement from your doctor can be proof of disability)**. Verification of medical expenses **(this can be a statement from your physician or pharmacist stating anticipated amount to be spent for medical expenses)**. You must be sixty-two (62) years or older, handicapped or disabled for this deduction. Anticipated amount to be spent for medical expenses $_____ *PROOF MUST BE PROVIDED*

I/We certify that the information given is true and correct to the best of my/our knowledge. I/We hereby authorized the Housing Authority to obtain any-and-all information necessary for the purpose of verifying the statement made above. I/We understand that any false statements are punishable under federal/tribal law. I/We understand that false statements or false information are grounds for termination of housing assistance and termination of tenancy.

HEAD OF HOUSEHOLD _____ **DATE** _____ **SPOUSE/OTHER ADULT** _____ **DATE** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT: I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to HOUSING AUTHORITY OF THE SAC AND FOX NATION any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Section 8, Rental Rehabilitation, Low-Income Public and Indian Housing, and/or other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies.

INFORMATION COVERED: I understand that, depending on program policies and requirements previous or current information regarding me or my household may be needed. Verification inquiries that may be requested but are not limited to:

IDENTENTY AND MARITAL STATUS **EMPLOYMENT, INCOME, ASSETS** **RESIDENCES AND RENTAL ACTIVITY**

MEDICAL OR CHILD CARE ALLOWANCES **CREDIT AND CRIMINAL ACTIVITY**

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for and continued participation in a housing assistance program.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED: The groups or individuals that may be asked to release the above information (depending on program requirements) include, but are not limited to:

PREVIOUS LANDLORDS	**PAST AND PRESENT EMPLOYERS**	**VETERANS ADMINASTRATION**
COURTS AND POST OFFICES	**WELFARE AGENCIES**	**RETIREMENT SYSTEMS**
SCHOOLS AND COLLEGES	**STATE UNEMPLOYMENT AGENCIES**	**BANKS/FINANCIAL INSTITUTIONS**
LAW ENFORCEMENT AGENCIES	**SOCIAL SECURITY ADMINISTRATION**	**CREDIT PROVIDERS/CREDIT BUREAUS**
SUPPORT AND ALIMONY PROVIDERS	**MEDICAL AND CHILD CARE PROVIDERS**	**UTILITY COMPANIES**

COMPUTER MATCHING NOTICE AND CONSENT: I understand and agree that HUD or the Public Housing Authority may conduct computer matching programs to verify the information supplied for my application or recertification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to disprove that information. HUD may in the course of its duties exchange such automated information with other Federal, State, or local agencies, including but not limited to: State Employment Security Agencies; Department of Defense; Office of Personnel Management; the U.S. Postal Service; the Social Security Agency; and State welfare and food stamp agencies.

CONDITIONS: I agree that a photocopy of this authorization may be used for the purposes stated above. This authorization will stay in affect for a year and one month from the date signed.

	PRINTED NAME	**SIGNATURE**	**DATE**
HEAD OF HOUSEHOLD:			
SPOUSE:			
ADULT MEMBER:			
ADULT MEMBER:			
ADULT MEMBER:			

WARNING: SECTION 1001 OF TITLE 18 OF THE U.S. CODE MAKES IT A CRIMINAL OFFENSE TO MAKE WILLFUL FALSE STATEMENTS OR MISPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE U.S. AS TO ANY MATTER WITHIN ITS JURISDICTION.

INTENTIONALLY LEFT BLANK

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INCOME VERIFICATION

In-order to establish eligibility for occupancy of public housing, the Housing Authority of the Sac & Fox Nation is required to verify the income of all tenants and household members above 18 years of age for public housing. The following has informed us that he/she is, or has within the past 12 months, been employed by your firm. Your cooperation and prompt return of the information requested below will be greatly appreciated. Such information will be held in confidence and used only by the HASFN as legally necessary. ****Form can be faxed back to number above or emailed.**

EMPLOYEE'S NAME: _____

EMPLOYEE'S PHONE NUMBER: _____

SOCIAL SERCURITY #: _____

EMPLOYED FROM: _____ TO _____

OCCUPATION/POSITION: _____

EMPLOYMENT IS: ( ) TEMPORARY ( ) FULL TIME
( ) SEASONAL ( ) PART-TIME

CURRENT PAY RATE: $ _____ PER _____

EFFECTIVE SINCE: _____ AVERAGE HOURS WORKED PER WEEK: _____

ACTUAL EARNINGS DURING THE PAST 12 MONTHS OR FOR PERIOD OF EMPLOYMENT IF LESS THAN 12 MONTHS:

FROM: _____ TO: _____ $ _____

EMPLOYER: _____ PHONE #: _____

EMPLOYERS'S SIGNATURE: _____

EMPLOYER'S TITLE: _____ DATE: _____

EMPLOYERS'S EMAIL: _____

*****THIS DOCUMENT CAN BE FAXED OR EMAILED BACK BY THE EMPLOYER*****

If the Head of Household and/or household member collects Social Security, SSI, and/or any other income that is provided from the government, a copy of your 2024 statement must be provided. Then you will not have to complete the Income Verification form. The copy of your statement will be a verification of your income.

*****The statement must be an updated form for this year. We cannot use the previous year's income.*****

FORM REVISED ON: 1/22/2021