



# Davis Community Housing Authority



PO Box 328  
Farmington, UT 84025

## PERSONAL INFORMATION DISCLOSURE

**BOTH SIDES MUST BE COMPLETED**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell / Message Phone: \_\_\_\_\_

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

**This form will be returned if information is incomplete.**

**Print Clearly**

| Full Name as shown on Social Security Card | Social Security Number | Date of Birth | Age | Disabled Y/N | Sex M/F | Relationship to Head of Household |
|--|------------------------|---------------|-----|--------------|---------|-----------------------------------|
|  |                        |               |     |              |         | Head of Household                 |
|  |                        |               |     |              |         |                                   |
|  |                        |               |     |              |         |                                   |
|  |                        |               |     |              |         |                                   |
|  |                        |               |     |              |         |                                   |

Emergency Contacts: Please provide the following information on two family members i.e. mom, dad, sister, or friends that can be contacted in case of emergency.

| Print Name | Relationship | Address | City, State, Zip | Phone Number |
|------------|--------------|---------|------------------|--------------|
|            |              |         |                  |              |

| Print Name | Relationship | Address | City, State, Zip | Phone Number |
|------------|--------------|---------|------------------|--------------|
|            |              |         |                  |              |

**INCOME: Must complete.**

**Source of income must be verified.** List of countable income: **Own Business, Federal Wages, Military Pay, Employment, School work study, State Assistance, Pensions, Social Security, SSI, Child Support, Medical Reimbursement, VA Benefits, help), Unemployment, Other Non-wage source** (family/friend/church). (Ask your coordinator if not sure if you have countable income.)

| Family Member Receiving Income | Type of Income | Income Source Address, phone number etc. (employer information) | Gross Monthly Income |
|--------------------------------|----------------|---|----------------------|
|                                |                |   |                      |
|                                |                |   |                      |
|                                |                |   |                      |

**2<sup>nd</sup> page must be completed in order to process change. If not applicable indicate with N/A**

**ASSETS**

Does any family member have the following Assets: Checking, Savings Certificates, Deeds, Real Estate, Stock/Bonds, Credit Unions, Whole Life Insurance?

| Family Member Name    | Type of Asset | Value of Asset |
|-----------------------|---------------|----------------|
|                       |               |                |
|                       |               |                |
| Explanation of Asset: |               |                |
|                       |               |                |

**Medical Information**

*(If head/spouse/co-head is 62 or disabled)*

Additional information may be attached on a separate paper. All Medical information must be verified by the source. (Example Dr, Pharmacy, Hospital, etc.)

| Family Member Name           | Medical Source<br>Dr, Pharmacy, etc. | Amount of Monthly<br>Payments |
|------------------------------|--------------------------------------|-------------------------------|
|                              |                                      |                               |
|                              |                                      |                               |
| Explanation of Medical cost: |                                      |                               |
|                              |                                      |                               |

**Day Care Information**

This deduction is for families that is Employed, Attending School, or looking for employment. If the State helps pay daycare a copy of contract must be submitted.

*(Day care verification must be submitted)*

| Day Care Provider Name | Day Care Provider Address<br>&/Phone Number | Children Name | Monthly Amount<br>Family Pays |
|------------------------|---|---------------|-------------------------------|
|                        |   |               |                               |
| Comments:              |   |               |                               |
|                        |   |               |                               |

I certify that all information reported to Davis Community Housing Authority on household composition, income assets, allowances and deductions is accurate and complete to the best of my knowledge. I also understand that giving false statements or information is grounds for termination of rental assistance. All members of the household 18 years and older are responsible for the rental assistance and must sign all forms required.

\_\_\_\_\_  
**Signature of Head of Household    Date**

\_\_\_\_\_  
**Signature of members 18 year old    Date**  
(Example: Spouse, Co-head, children, etc.)

Davis Community Housing Authority complies with Section 504 of the Rehabilitation Act of 1973 in providing individuals equal access to services, program and activities the Housing Authority offers. Upon written request, the Housing Authority will provide reasonable accommodation to individuals with disabilities.

All persons will be treated fairly and equally without regard to race, color, religion, sex, familial status, disability or national origin in compliance e with the Fair Housing Act.

*WARNING: Section 1001 of Title 18 of the US Code makes it a criminal offense to make willful false statements or misrepresentation to any Department or Agency as to any matter within its jurisdiction.*