



THE TOPEKA HOUSING AUTHORITY

2010 SE California Ave. ■ Topeka, KS 66607

Phone: 785-357-8842 ■ Fax: 785-357-2648 ■ www.tha.gov

PLEASE STOP AND READ!

If you are completing a change of income or family members packet and if your packet is not complete it will be returned to you and will no longer be accepted.

Your change packet must be complete and you must submit all updated documents for ALL household members before your change will take effect.

All adult members of the household must sign ALL forms certifying the information is correct.

Thank you.



Topeka Housing Authority

2010 SE California Ave
Topeka, KS 66607-1444
Phone (785) 357-8842 FAX (785) 357-2648

Staff Use Only
Verification(s) sent

CHANGE IN INCOME OR FAMILY MEMBERS

Section 8 _____ Public Housing _____ Mainstream _____ VASH _____ FSS _____

Head of Household Name: _____

Today's Date: _____

Give brief description of your change: (i.e., for employment, give name of employer and start or termination date, adding or removing child, etc.)

I am reporting the following change(s): (Check all that apply)

- _____ Increase in income as of _____ (date)
- _____ Decrease in income as of _____ (date)
- _____ Change in family members as of _____ (date)
- _____ Change in child care or medical expenses as of _____ (date)
- _____ Add child or remove adult as of _____ (date)

You must submit all current documents. This may include any of the following:

- SRS letter (TAF, FS, Child Care)
- Unemployment
- SS/SSI/SSDI Benefit Letter
- Offer of Employment Letter
- Termination Letter
- Current Paycheck stub(s)
- To Add Child/ren Need:
 - Birth certificate/announcement
 - SS card
 - Custody documents
- To Remove Household Member Need:
 - Copy of New Lease
 - Copy of utility bill showing new address
 - Statement from Landlord

FILL OUT ALL FORMS THAT APPLY TO THE CHANGE FOR YOUR HOUSEHOLD AND ATTACH YOUR DOCUMENTS OR YOU MAYBE REQUIRED TO ATTEND AN APPOINTMENT AT A LATER DATE. ALL ADULT MEMBERS OF THE HOUSEHOLD MUST SIGN ALL THE FORMS CERTIFYING THE INFORMATION IS CORRECT.

TOPEKA HOUSING AUTHORITY TENANT DECLARATION

For Interims and RFTA's

This form must be completed in your own handwriting. You must use the correct legal name for each member of your household. All adult members of the household must sign this form certifying the information pertaining to them. Please print.

I. HOUSEHOLD COMPOSITION: List all persons who are living in your home, listing head of household first.

FAMILY MEMBER (LEGAL NAME)	DATE OF BIRTH	FAMILY MEMBER (LEGAL NAME)	DATE OF BIRTH
1		6	
2		7	
3		8	
4		9	
5		10	

II. TOTAL HOUSEHOLD ANTICIPATED INCOME: List **all** sources of current and anticipated income for everyone living in your household. This includes money from wages, child support, self employment, contributions, social security, disability payments (SSI), workers compensation, retirement benefits, AFDC, veterans benefits, rental property income, stock dividends, income from bank accounts, alimony, and **all other sources.**

Answer every question. For each "yes" answer, provide details.

No Yes

Social Security:

SSI/SSDI \$ _____ Name of recipient: _____

SSI/SSDI \$ _____ Name of recipient: _____

SS \$ _____ Name of recipient: _____

No Yes

DCF:

Cash \$ _____ Food Stamps: \$ _____

No Yes

Employed: (1st job or 1st adult/minor child(ren))

Name of person working: _____

Name of employer: _____

Address of employer: _____

Hours worked per week: _____ Hourly Wage: \$ _____ Date Started: _____

No Yes

Employed (2nd job or 2nd adult/minor child(ren))

Name of person working: _____

Name of employer: _____

Address of employer: _____

Hours worked per week: _____ Hourly Wage: \$ _____ Date Started: _____

No Yes

Child Support Ordered by the Court

Receiving?

No Yes Court Order #: _____

(circle one)

Amount: \$ _____ weekly/biweekly/monthly

No Yes Court Order #: _____

Amount: \$ _____ weekly/biweekly/monthly

County and State where Child Support is Ordered: _____

___ No ___ Yes

Pension/Retirement Benefits:

Amount: \$ _____ Received from: Name _____
Address _____
City, State, Zip _____

___ No ___ Yes

Receive School Loans or Grants:

Amount: \$ _____ Name of School: _____

___ No ___ Yes

Is anyone in your household over the age of 18 years old and in high school:

Name of School: _____

___ No ___ Yes

Unemployment:

Amount: \$ _____ per week Date of First Payment Received: _____
Date of First Week Claimed: _____

___ No ___ Yes

Per Capita:

Amount: \$ _____ # of times received per year: _____
Received from: _____

___ No ___ Yes

Other Income:

Amount: \$ _____ Received from: Name _____
Address _____
City, State, Zip _____

___ No ___ Yes

Does anyone outside of your household pay for any of your bills or give you money on a regular basis?

Amount: \$ _____ weekly/monthly (circle one)
Received from: Name _____
Address _____
City, State, Zip _____

Explanations for any of the above incomes if needed:

THE INCOME REPORTED ON THIS FORM WILL BE VERIFIED AND WILL BE USED FOR YOUR MOVE IN EVEN IF ACTUAL INCOME IS DIFFERENT WHEN YOU MOVE IN!

III. EXPENSES:

___ No ___ Yes

Do you pay for child care?

Amount you pay \$ _____ weekly/bi-weekly/monthly (circle one)

Child Care Provider Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____

___ No ___ Yes

Elderly/Disabled only: Do you have any new medical expenses that you pay out of your pocket that you have not already reported to the Housing Authority? If yes, please provide names and addresses of doctors or hospitals below. If you pay for prescription medicine, you will need to provide a computer print out from each pharmacy for the last twelve months.

I do hereby swear and attest that all of the information above about me is true and correct. I also understand that **all** changes in the income of any family member of the household, and **all** changes in family composition must be reported to the Housing Authority **in writing within 30 days** of the change. I also understand that falsifying information can lead to my housing assistance being cancelled.

Signature of Head of Household Date

Signature of Other Adult Date

Home Address

Signature of Other Adult Date

Phone Number Home/Work

Signature of Other Adult Date

Email Address

THA Staff Date



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2010 S.E. CALIFORNIA AVENUE
TOPEKA, KANSAS 66607
Phone (785) 357-8842 FAX (785) 357-2648

AUTHORIZATION TO RELEASE INFORMATION

Name _____

Social Security Number _____

In order to cooperate in the determination of my initial or continuing eligibility for tenancy, I authorize the Topeka Housing Authority to use this authorization and the information obtained with it to administer and enforce rules and policies.

Any individual or organization, including any governmental organization may be asked to release information. For example, information may be requested from: Banks and other financial institutions, courts, law enforcement agencies, credit bureaus, landlords, present or past employers, any federally subsidized rental assistance program, Social Security Administration, Veteran's Affairs, welfare agencies, utility companies, unemployment compensation, pensions/annuities, child care providers, any medical providers, and the United States Postal Service.

I hereby authorize the above persons, firms or corporations or any others it may be necessary to contact to make available any documents or records concerning me to the Topeka Housing Authority for inspection and copying.

This release will expire 15 months from the signature date.

Signature _____ Date _____



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Topeka Housing Authority
2010 SE California
Topeka, KS 66607

APPLICANT/TENANT CERTIFICATION

APPLICANT(S)'S/TENANT(S)'S STATEMENT

I/We certify that the information* given to the Topeka Housing Authority on household composition, income, net family assets, and allowances and deductions is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements of information are punishable under the Federal Law and applicable State Laws. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

Signature of Head of Household

Date

Signature of Spouse/Other Adult

Date

Signature of Other Adult

Date

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-Free Hotline at 800-424-8590. (Within the Washington, DC metropolitan area, call 426-3500.)

*After verification by this Housing Authority, the information will be submitted to the Department of Housing and Urban Development on form HUD-50058 (Tenant Data Summary), a computer generated facsimile of the form or on magnetic tape. See the Federal Privacy Act Statement for more Information about this use.

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HUMAN SERVICE GRANT VERIFICATION (TANF, GA, ETC)

HUMAN SERVICE OFFICE: Topeka DCF
 ADDRESS: PO Box 1424
 CITY, STATE, ZIP: Topeka, KS 66601-1424

PERMISSION FOR RELEASE OF INFORMATION:

I Authorize you to furnish the information requested below to the Topeka Housing Authority for the purpose of determining my eligibility for housing assistance. I understand that I have the right to rescind this authorization in writing at any time, but that to do so may affect my application for admission/continued occupancy.

NAME(S) OF APPLICANT & HOUSEHOLD MEMBERS:	SOCIAL SECURITY#(S):
SIGNATURE OF ADULT:	DATE:

***** DO NOT WRITE BELOW THIS LINE *****

TYPE(S) OF ASSISTANCE/INCOME RECEIVED:

TANF	\$ _____	SSDI	\$ _____
GA	\$ _____	MA	\$ _____
SSI	\$ _____	_____	\$ _____
		_____	\$ _____

Has this person worked in the last year? YES ___ NO ___

PRINTED NAME OF PREPARER:

SIGNATURE OF PREPARER:	DATE:
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Thank you for your cooperation. All information is confidential. Please return this form by fax (785) 357-2648 or mail. If you have any questions, please feel free to contact our office at (785) 357-8842.

Housing Specialist



THE TOPEKA HOUSING AUTHORITY

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EMPLOYMENT VERIFICATION

Employer	Phone
Employer Address	FAX
Employer City, State, ZIP	

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to furnish the information requested below to the Topeka Housing Authority for the purpose of determining my eligibility for housing assistance. I understand that I have the right to rescind this authorization in writing at any time, but that to do so may affect my application for admission/continued occupancy.

Applicant – Printed Name	Social Security Number
Applicant Signature	Date

STOP HERE – THE SECTION BELOW IS TO BE COMPLETED BY THE EMPLOYER**Please provide information on Gross Earnings based on the employee's current employment status.**

Currently Employed?	Current Wage/Salary \$ _____
<input type="checkbox"/> YES Date First Employed _____	(Check one) <input type="checkbox"/> Per Hour <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly
<input type="checkbox"/> NO Last Day of Employment _____	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____

Please provide the last year of payroll history

Average number of hours worked per week _____	Gross Year-to-Date Earnings \$ From ___/___/___ To ___/___/___
---	---

Is Shift Differential pay received for any of the hours worked? <input type="checkbox"/> No <input type="checkbox"/> Yes	If <u>yes</u> , average number of hours for per week for which Differential pay is received _____ Hours	Shift Differential rate of pay \$ _____ per hour
--	---	--

Is Overtime Pay received for any of the hours worked? <input type="checkbox"/> No <input type="checkbox"/> Yes	If <u>yes</u> , average number of hours per week for which Overtime Pay is received: _____ Hours	Overtime Rate \$ _____ per hour
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Bonus, incentive, commission and/or tips? <input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____ (Check one) <input type="checkbox"/> Per Hour <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____
---	--

List any anticipated change in the employee's rate of pay within the next 12 months \$ _____ per _____	Effective Date ___/___/___
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If the employee's work is seasonal or sporadic, please indicate the layoff period(s).

Anticipated Layoff Dates: _____ to _____ Total: Days _____ Weeks _____ Months _____

Additional Remarks

Printed Name of Preparer	Phone
Signature of Preparer	Date

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TERMINATION OF EMPLOYMENT VERIFICATION

EMPLOYER NAME:

ADDRESS:

CITY, STATE, ZIP:

PERMISSION FOR RELEASE OF INFORMATION:

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NAME(S) OF APPLICANT:

SOCIAL SECURITY #(S):

SIGNATURE:

DATE:

***** DO NOT WRITE BELOW THIS LINE *****

DATE EMPLOYED:

DATE OF TERMINATION:

LAST DAY WORKED:

Will employee receive additional pay for unused vacation or sick leave? YES ___ NO ___
If YES, please list amount employee will receive \$

Will employee receive additional pay for workmen's compensation? YES ___ NO ___
If YES, give name and address of company through which this may be verified:

REASON FOR TERMINATION:

Employee Quit ___ Terminated for Cause ___ Lack of Work ___ Other

If terminated for lack of work or other, do you anticipate re-hiring this employee?

YES ___ NO ___ If YES, when: _____.

SIGNATURE OF PREPARER:

DATE:

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THA Housing Specialist

REQUEST FOR DISCLOSURE OF TAX/BENEFIT INFORMATION

K-RM 002 (Rev. 8-13)

MAIL TO: Disclosure Officer
Kansas Department of Labor
P.O. Box 3539
Topeka, KS 66601-3539
FAX TO: (785) 368-7117

Information requested: _____

Information will be used for: _____

SECTION A – CLAIMANT

This request is submitted by a claimant or in reference to a Kansas unemployment claimant. **Information requested by a claimant will only be mailed to the claimant.**

Claimant Social Security number: _____

Claimant name: _____

Claimant address: _____

City: _____ State: _____ ZIP: _____

SECTION B – EMPLOYER

This request is submitted by an employer or in reference to a Kansas employer's account.

Employer account number: _____

Employer name: _____

Unemployment tax returns:

Quarters _____ Years _____

SECTION C – PUBLIC OFFICER OR EMPLOYEE

This request is submitted in the performance of public duties by an authorized officer or employee of:

Local government branch name: _____

Federal government branch name: _____

State government branch name: _____

Law enforcement agency name: _____

Other: _____

Send information to: _____

Information maintained in the KDOL files may only be disclosed as provided for in K.A.R. 50-4-2 and K.S.A. 44-714(e).

CERTIFICATION: I understand this information is being released in accordance with the Employment Security Law, K.S.A. 44-714(e), which provides for disclosure of information to...*“public employees in the performance of their public duties...”* The information retains its confidential nature and *“...shall not be published or be open to public inspection... in any manner revealing the individual's or employing unit's identity...”* I further understand this information is being supplied with the express understanding that the recipient will treat this information in a confidential manner and refrain from disclosing the information or allowing it to be published as part of a public record in any proceeding.

(SIGNATURE MUST BE NOTARIZED)

By my signature, I further authorize and consent to the disclosure and copying of these records for the above mentioned purposes. I further attest that I acknowledge the guidelines of disclosure as mentioned in K.A.R. 50-4-2 and K.S.A. 44-714(e).

Requestor printed name: _____ Title (if applicable): _____

Signature: _____ Date: _____ Phone: _____

BE IT REMEMBERED, that on this _____ day of _____, 20____, before me personally appeared _____, known to me to be the person named in and who executed the foregoing instrument of writing and acknowledges the execution of the same.

State of _____ NOTARY PUBLIC: _____

County of _____ My commission expires on: _____