

IRON COUNTY HOUSING COMMISSION APPLICATION FOR HOUSING SERVICES

AF	PLIC	ANT INFORMAT	ION	- PI	EASE PRI	NT IN INK					
Na	me (F	irst, Middle, Last)					Date of	f Birth	Pho	one Nu	mber
Current Address					City			State	Zip		
Nev	w Addr	ess: Office Use Only			City		:	State	Zip		
Nar	ne of r	person and phone nu	mhor	who	ro you can be	roophad	Dalatia				
							Relatio		Yes		essage?
PR	OVIDI	ALL INFORMATION	ON R	EQL	JESTED & A	NSWER AL	L QUES	TIONS BEL	ow		
	wno a	ourself first and all others are temporarily absent talization.	ner pe from	erson your	s who will be I home due to r	iving in your military servic	home. Inc e, educat	clude persons ion or	A=Asiar N=Nativ	B=Black e America slander W	n P=Hawaiian or
	1	NAME - List applican (Last, First, Middle)			Relationship to	Date of Birth Mo/Day/Year		Security Number	U.S. Citizen Y or N	Sex M or F	Marital Status M=Married N=Never married D=Divorced W=Widowed S=Separated
1					Self						
2			21								
3							_				
4									-		
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5											
6											
7											
8 s an	y perso	n ·	Ivos	LNo	If yes, who?	IVA/IO					
	ding so	hool	163	190	in yes, who?	Who?		Who?	al T	Who?	
		Name of School:									
		Address:									
		City, State: Telephone #:	g x 2 x 3.								
any	y perso		Yes	No	If yes, who?	Mha		100			-
_		nd or unable to work	163	14,0	ii yes, who?	Who?		Who?		Who?	1 - 1
regr						Due Date:				Due Date	î.
		on been convicted of a an a traffic violation?			Who: When:	Who: When:		Who: When:		Who: When:	
a di	isable	person listed above	is w	orkin	g, please ansv	ver the follow	vina:			7.1	Voo Nie
as ti	nis per	son been unemployed t	for on	e yea	ar or longer price	or to becoming	employe	d?			Yes No
unis	perso	n participating in any ty	pe of	econ	omic self-suffic	iency program	m2			7 4	
as th	nis per	son received TANF (we	elfare	ben	efits in the past	six months, i	ncluding c	one time paym	ents?	17.	

Name of person with earnings:	ver all Questio	Start Date	persons w	ho are self-em	are self-employed				
, or or man garmings.		- Start Date		The second secon	Will employment continue?				
Employer Name & Address				☐ Yes					
Employer Name & Address		Monthly pay b	efore taxes	Monthly pay	Monthly pay after taxes				
Average # of hours/week		How often pai		Day of week	paid Last	pay date			
		☐ Weekly ☐ ☐ Every 2 we		ith	The state of the s	an Paris and The State of the S			
Rate of Pay		Maria galas da an il man d'an		Tips/bonus re	pc'd Ava	tips per week			
\$ Hourly \$	Salary \$	S(Other		그러나 보고 있어요 하고 있다는 이번 한 경기를 마하하였다고 있어졌다. 하이에 가지 하면 유민이었다면 그는 이번에 보면서 보면서 되어 되어 있다면 있었다. 하는				
Name of person with earnings:		Start Date			Will employment continue?				
Employer Name & Address		Monthly pay be	efore taxes	☐ Yes Monthly pay a		No			
Average # of hours/week		How often paid ☐ Weekly ☐ ☐ Every 2 wee	I? Twice a mon	Day of week	and historical environment of the constraints of th	pay date			
Rate of Pay		The Every 2 week	eks Liottiei	Tips/bonus re	oc'd Ava	tips per week			
\$ Hourly \$	Salary \$	C	ther		☐ Yes ☐ No				
Name of person with earnings:		Start Date			Will employment continue?				
		× 1			The state of the s				
Employer Name & Address		Monthly pay be		☐ Yes	☐ Yes ☐ No Monthly pay after taxes				
Average # of hours/week		How often paid ☐ Weekly ☐ ☐ Every 2 wee	Twice a mont	Day of week p	paid Last	pay date			
Rate of Pay		= zvoiy z wee	NO LIOUTOI	Tips/bonus re	Tips/bonus rec'd Avg tips per				
\$ Hourly \$	Salary \$	O	ther						
OTHER INCOME:									
Does anyone receive money from: Yes	If yes, who receives?		Claim #	If yes, who receives?	Monthly Amount	Claim #			
Social Security Benefits (RSDI)									
Supplemental Security ncome (SSI)			State Qtrly \$	- 0.		State Qtrly \$			
Veterans' Benefits									
How often paid? W = weekly M=	Monthly T=Twice	e a month	How often	189		How often			
E=Every other week O=Other (ple Workers Compensation	ease state):		paid			paid			
Other Disability Benefits					-				
Child Support			-			-			
Jnemployment benefits									
Retirement Benefits						-			
Military Allotments					-	<u> </u>			
IA Benefits - Indicate	Who	Amt	Туре	Who	Amt	Туре			
nonthly amount	Who	Amt	Туре	Who	Amt	Туре			
Oo you receive any other noney? Please specify.						,,			

ASSETS: Comp	ete this se	ction	by pro	oviding	reque	ested infor	matic	n. incl	uding assets	held injustry	
- ood dily person in	ave any of			Maille	(3) 0	1 1110	lame	& addr	ess of bank or	Account	
the following:		Yes	No	ac	account			financ	ial institution	Number	Balance
Checking/Draft acc	ount				,					- Hamber	Dalatice
Money Market Acco											_
Savings/Share Acco											
Certificates of Depo	sits (CD)										
Christmas Club Acc	ounts									T .	
Other, please list											
No.						If yes, g				If yes, give	
Does any person ha	ve any of th	ne foll	owing:	Yes	No	amount/v	alue	O	wner(s) a	mount/value	Owner(s)
Cash on hand or in a	safe depo	sit bo	X	. 301	-						
Real Estate, including	g income p	roduc	ing								
property		10.00			-	-	_				
Mortgage, land contr to a household mem	act or other ber	r note	s payal	ble							
Savings Bonds, Stoo		al Fun	ds				+				
IRA, KEOGH, 401K	or Deferred	Com	pensati	ion			_				
Account(s)		00,					- 1				
Trust Funds							+	***************************************			
life Insurance or Ann	uity						\dashv	-			
Prepaid Funeral Agre	ements										
ars, watercrafts, sr lame of vehicle owne ehicle title or registra	er(s) as sho	s, mo	n			rehicle	mes, Ye:		Color/M	lake/Model	License Plate #
										-	
AV CARE EVE	VOE DI			lata ti	20 £0		7. 6				
AY CARE EXPE	NSE - PIE	ease	comp	olete ti	ie ic	ollowing			e a day car receive help	e expense	
lame of Child	Reason ca	are is		Cos	st of	How ofte	n pav	ing for	care (circle fo	r If yes na	me of source
eeding care	neede		Age	Ca	are	paid	1,-7	eac	h child)	providing the	help & amoun
									T		
							+	Yes	No		\$
							_	Yes	No		\$
W.M.			1		7			Yes	No		\$
			-					Yes	No		\$
								Yes	No		\$
ame and Address of F	Percon(a) =	rovidi	00000			l		Yes	No		\$
1.001655 011	erson(s) p	ioviair	ig care	•							

reimbursed) for the following medical expenses? Doctor Visits Prescriptions or Over-the-counter meds Vision Care Dental Medicare Premiums Supplemental Health Ins Transportation to a Health Care Provider Unpaid Old Medical Bills Other Medical Expenses - Please list expense and complete the questions: Yes No If yes, who? Any household member Amount? Amount? Amount? Amount? Circle response) Yes No No No No Do you expect this expense to continue? (circle response) No	MIEDICAL EX	PENSES for House	hold	s wh	ose head or s	pous	e is Dis	abled	or El	derly (over	62)
expenses? Doctor Visits Prescriptions or Over-the-counter meds Vision Care Dental Medicare Premiums Supplemental Health Ins Transportation to a Health Care Provider Ungaid Old Medical Bills Other Medical Expenses - Please list expense and complete the questions: Yes No Transportation to a Health Care Provider Ungaid Old Medical Bills Other Medical Expenses - Please list expense and complete the questions: Yes No Transportation to a Health Care Provider Ungaid Old Medical Bills Other Medical Expenses - Please list expense and complete the questions: Yes No Transportation to a Health Care Provider Ungaid Old Medical Bills Other Medical Expenses - Please list expense and complete the questions: Yes No Transportation to a Health Care Provider Any household How often paid? Amount? Tess No Do you expect this expense to continue? Yes No Yes No Do you expect this expense to continue? Yes No Yes No Transportation to a Health Care Provider No Transportation to a Health Care Provider No Tess No Tess No Amount? Tess No Do you expect this expense to continue? Yes No Yes No Tess No Amount? Court Ordered Support Amount of Court Ordered Support Amount of Amount of support being paid (include cash payments) How often Address of Absent Parent Signature of Child support participation payment from FIA? Yes No If yes, who? Any household who has a parent not in the home Amount? Court Ordered Support Amount? Amount of Court Ordered Support Amount? Amount	nas anyone paid out-of-pocket (not				If yes, who?						
expenses?					Any household	Hov	v often				
Decider Vision Care Prescriptions or Over-the-counter meds Vision Care Dental Medicare Premiums May household Medical Bills Medicare Premiums May household Medical Bills May household How often member May household Who has a parent not in the home Amount of Court Ordered Support May household May parent not in the home Amount of Court Ordered Support May household May parent not in the home Amount of Court Ordered Support May household May household May have a parent not in the home Medicare Premiums May household Who has a parent not in the home Amount of Court Ordered Support May household May household May have a parent not in the home May household M	。			No				Amount?			
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Dental Wedicare Premiums Yes No No Yes No					8						
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Other Medical Expenses - Please list expense and complete the questions: No					If ves who?	and the even		Secretary Control			To Charles Charles to Annual Section Co.
expense and complete the questions: Yes No member paid? Amount? (circle response) Yes No Yes	Other Medical E	xpenses - Please list									
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