CAMBRIDGE HOUSING AUTHORITY

675 Massachusetts Avenue
Cambridge, MA 02139
www.cambridge-housing.org
TDD 800-545 1833 x112

Una versión en Español de este documento está disponible en su Oficina de Gestión, en la Oficina Central del CHA o en la página web de CHA: www.cambridge-housing.org
Yon vèsyon Kreyòl Ayisyen pou dokiman enpòtan sa-a disponib nan Biwo Administrasyon-a, nan Biwo Santral CHA, epi nan sit intènèt CHA: www.cambridge-housing.org.
A versão em Português deste documento está a sua disposição no seu Escritório de Gerencia, no Local Central de Gerencia do CHA, e no Website do CHA: www.cambridge-housing.org

CERTIFICATION QUESTIONNAIRE – LEASED HOUSING

Instructions: The head of household should complete every applicable item on this questionnaire. Every item listed below must be completed on behalf of **every member of the household.**. The questionnaire must be signed by the Head of Household and CHA staff. If needed, CHA staff may provide you with assistance in completing this questionnaire.

TO BE COMPLETED BY HEAD OF HOUSEHOLD

Head of Household/Participant Name ______________________ Phone Number ______________

Head of Household/Participant Address ______________ City, State ______________ Zip Code ______________

1. Please indicate the type of Recertification: ☐ Interim Recertification ☐ Annual/Biennial Recertification ☐ Lease Up
2. Please indicate if the Head of Household, Co-Head and/or Spouse is Elderly or Disabled: ☐ Elderly ☐ Disabled
3. Please list all household members on the chart below:

Full Name of Member	Relation-ship to Head of Household	Date of Birth (MM/DD/YYYY)	Monthly Income	Source of Income	Medical Expense	Child Care Expense	Full Time Student
	Head		$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			$________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TAFDC/EAEADC ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you need additional space, please attach another page. Make sure to indicate which question you are answering

Name of Head of Household: _____

4. Did any family member lose a job or voluntarily leave their job since the last recertification? If yes, list names and the effective date of the job loss below? ☐ Yes ☐ No

Name of Family Member	Effective Date

5. Will anyone in the family receive monetary or non-monetary gifts or contributions on a regular basis from someone who does not live in the household? ☐ Yes ☐ No

If yes, list names of family members who will receive such contributions, the type of contribution and the monthly amount of the contribution. For example if you receive $50 worth of groceries every week from your Uncle Bill you would enter your name, under type of contribution, you would enter groceries, and under monthly amount you would enter $200 ($50/week x 4 weeks) :

Name of Family Member	Type of Contribution	Monthly Amount

OTHER INCOME

6. If you selected "Other Income" for any family member, complete the table below by placing a check in the column if the income type is applicable to a family member and entering the name of the family member who receives that type of income.

Income	Check if Applicable	Name of Family Member
Unemployment Benefits		
Annuities, Insurance, Retirement, Pension		
Disability or Death Benefits		
Payments for Support of a Foster Child		
Payments for a Member of the Armed Services If yes, if the Armed Services member exposed to hostile fire? ☐ Yes ☐ No		
Lottery Payments		
Other Income _____ Describe		
Other Income _____ Describe		
Other Income _____ Describe		

ASSETS

7. Does your household have assets worth more than $50,000?
☐ Yes ☐ No

Name of Head of Household: _____

8. Complete the table below about your family assets. Place a check in the column if a family member has the type of asset listed, enter the amount of the asset and the name of the family member who owns the asset.

Asset	Check if Applicable	Name of Family Member	Amount of Asset
Checking Account			
Savings Account			
Stocks			
Bonds			
Mutual Funds			
Money Market Funds			
Certificates of Deposits			
Annuity			
Property/Real Estate			
Trust Funds			
Retirement or Pension Funds			

9. Does anyone in the family expect to receive any lump sum payments from insurance settlements or legal claims?
☐ Yes _____ ☐ No
Enter Amount and Description of the Lump Sum Payment

10. Does anyone in the family have a "whole life" insurance policy?
☐ Yes _____ ☐ No
Enter Amount

11. Has anyone in the family disposed of any assets for less than they were worth in the past two years?
☐ Yes ☐ No

Adjusted Income

Childcare Deduction

12. Is the family paying for care of children under age 14 so an adult can work? ☐ Yes ☐ No

13. Is the family paying for the care of children under age 14 so an adult can attend education or job training classes?
☐ Yes ☐ No

14. Is the family paying for the care of children under age 14 so an adult can look for work? ☐ Yes ☐ No

Disability Expense Deduction (Eligible only if member's income is included in Annual Income)

15. Is the family paying for care or apparatus for a disabled family member so that an adult family member can work?
☐ Yes ☐ No

16. If yes, list name(s) of person with disability who is receiving care or using the apparatus:

_____
Name of disabled family member receiving care or using apparatus

17. Cost of care or apparatus: $_____per month

Un-reimbursed Medical Expense Deduction (Applicable only to families if the head of household, co-head and/or spouse is elderly or disabled)

18. Does the family expect un-reimbursed medical expenses over the period covered by the certification?
☐ Yes ☐ No

19. List names of family members who expect un-reimbursed medical expenses:

_____ _____
Name of Family Member Name of Family Member

Name of Head of Household: _____

20. Check type of **un-reimbursed** medical expenses anticipated and enter annual expense:

Type of Expense	Check if Applicable	Annual Amount
Medical insurance premiums (including Medicare)		
Doctor visits		
Dentist visits		
Dentures, bridgework or crowns		
Eye doctor visits		
Eyeglasses or contact lenses		
Clinic visits		
Therapy (physical or emotional)		
Lab fees, x-rays, blood work		
Prescription medicine		
Non-prescription medicine		
Hearing aid batteries		
In-home health care		
Medical Transportation		
Medical apparatus (owned or rented)		
Assistive animal expense		
Hospice care		
Other (describe)		
Other (describe)		

Other Information

21. Are you currently responsible for payment of utilities? ☐ Yes ☐ No

22. If yes, are you current on your payments to the utility provider? ☐ Yes ☐ No

23. Are you current on your rent payments to your landlord? ☐ Yes ☐ No

24. Has your apartment been inspected within the last twenty four months? ☐ Yes ☐ No

Emergency Contact

In case of an emergency for your or a household member, whom should we contact?

Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Other Phone _____

Participant Certification

I declare that I have fully reviewed this completed questionnaire and that all of the above information is accurate and complete to the best of my knowledge and belief. I understand that false statements or information are punishable by Federal Law. I also understand that making false statements is grounds for termination of housing assistance and termination of tenancy with the Cambridge Housing Authority. Title 18 Section 1001 of the United States Code, states that a person who knowingly and willfully makes false statements to any department or agency of the United States Government is guilty of felony.

Signature of Head of Household _____ Date _____

Name of Head of Household: _____

CHA Certification

_____ _____
CHA Employee Signature Date

_____ _____
Telephone Number Fax Number

Check the program that applies:

- ☐ MTW
- ☐ Non-MTW
- ☐ PB
- ☐ Mod Rehab
- ☐ SRO
- ☐ Enhanced
- ☐ MRVP
- ☐ AHVP

CHA staff must make a copy of the completed and executed Recertification Questionnaire. CHA should retain the original and provide a copy to the participant.