BERKSHIRE HOUSING
CONNECTING PEOPLE TO HOME

FAMILY CERTIFICATION FORM
HOUSING CHOICE VOUCHER PROGRAM

Instructions: The Head of Household must complete and submit this form at the time of regular and, if required, interim recertification. Every item listed below must be completed on behalf of **every member of the household**. The form must be signed by the Head of Household.

TO BE COMPLETED BY HEAD OF HOUSEHOLD

Head of Household/Participant Name ______________________ Last Four Digits of SS No. ____________

Head of Household/Participant Address ______________________

Home Telephone:______________________ Work #: ______________________

Cell Phone/Pager:______________________ Email: ______________________

Completed By:______________________ Date: ______________________

1. On the chart below please list all household members living in your unit 50% or more of the time. If you need additional space, please attach another page. Make sure to indicate which question you are answering.

Full Name of Member	Relation-ship to Head of Household	DOB	Sex	Ethni-city	Race	Income	Source of Income	Disabled	Full Time Student
	Head		☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No
			☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No
			☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No
			☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No
			☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No
			☐M ☐F	☐H ☐NH	☐1 ☐2 ☐3 ☐4 ☐5	$___________/ per___________	☐ Wages ☐ SS/SSI/SSDI ☐ Child Sup/Alimony ☐ Pension ☐ TANF ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No

Sex Categories: M = Male F = Female
Ethnicity Categories: H = Hispanic NH = Non Hispanic
Race Categories: 1 = White 2 = Black/African American 3 = American Indian/Alaska native 4 = Asian
5= Native Hawaiian/Other Pacific Islander

2. What is the primary language spoken in your home?

☐ English ☐ Spanish or Spanish Creole ☐ Portuguese or Portuguese Creole ☐ Vietnamese
☐ French Creole ☐ Italian ☐ Russian ☐ Chinese ☐ Mon-Khmer, Cambodian
☐ Other _____

3. If you prefer to receive written communication from DHCD in a language other than English, please check the langue that you prefer. DHCD is required to provide written translation of materials for languages spoken by a significant percentage of households in its jurisdiction. Accordingly, DHCD will provide written translations for the languages indicated below:

☐ English ☐ Spanish or Spanish Creole ☐ Portuguese or Portuguese Creole ☐ Vietnamese
☐ French Creole ☐ Italian ☐ Russian ☐ Chinese ☐ Mon-Khmer, Cambodian
☐ Other _____

Do you need interpretation/translation services when communicating with Berkshire Housing regarding?

☐ Yes _____ ☐ No
Language

4. Did any household 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 ☐ N/A

_____ _____
Name of Household Member Effective Date

_____ _____
Name of Household Member Effective Date

5. Will anyone in the household 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 household 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

_____
Name of Family Member Type of Contribution Monthly Amount

Emergency Contact

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

_____ _____
Name Relationship

_____
Address City State Zip Code

_____ _____
Home Phone Other Phone

OTHER INCOME

6. If you selected "Other Income" for any household member, complete the table below by entering the monthly amount and name of household member who receives that type of income.

Income	Amount Per Month	Name of Household Member
Commissions, Tips, Bonuses & Other Income		
Disability or Death Benefits		
Veteran's Benefits		
Veteran's Disability Benefits		
Payments for a Member of the Armed Services If yes, is the Armed Services member exposed to hostile fire? ☐ Yes ☐ No		
Unemployment Benefits		
Interests, Dividends or Capital Gains		
Lottery or Gambling Winnings		
Real Estate or Rental Property Income		
Income from an Inheritance		
Insurance, Retirement, Pension, Life Insurance		
Payments for Support of a Foster Child		
Other Income _____ Describe		

Adjusted Income

Childcare Deduction

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

Disability Expense Deduction (Eligible only if the head of household, co-head and/or spouse is elderly or disabled)

10. Is the family paying for care or apparatus for a disabled family member so that an adult family member can work? ☐ Yes ☐ No
11. 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

12. 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)

13. Does the family expect un-reimbursed medical expenses over the period covered by the certification? ☐ Yes ☐ No
14. List names of family members who expect un-reimbursed medical expenses:

    _____ _____
    Name of Family Member Name of Family Member

15. 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)	☐	

Criminal Background Information

Are you or any member of your household subject to a lifetime state sex offender registration program in any state?

☐ No ☐ Yes - If yes, state the household member name and the state in which the household member is subject to a lifetime state sex offender program: _____ _____
Member name State

Have you or another member of your household ever been convicted of the manufacture or production of methamphetamine on the premises of Federally-assisted housing?

☐ No ☐ Yes - Name of Household Member _____

Have you or any member of your household been evicted from public housing due to violent or drug-related criminal activity?

☐ No ☐ Yes - Name of Household Member _____

Have you or any member of your household been evicted due to alcohol abuse which threatened the health, safety, or right to peaceful enjoyment of the premises by other residents or neighbors in the vicinity of your residence?

☐ No ☐ Yes - Name of Household Member _____

Have you or a member of your household ever used a Social Security Number other than the ones listed on this application?

☐ No ☐ Yes - Name of Household Member & SS Number _____

_____

Have you or a member of your household ever been convicted of a felony?

☐ No ☐ Yes - Name of Household Member and offense _____

_____

Participant Certification

Third party verification of the above information will completed and the results will be electronically transmitted to the HUD data collection system. Please refer to the Federal Privacy Act Statement for more information on its use.

I hereby certify that the above information on household composition, income, and assets is complete, true and correct to the best of my knowledge. I understand that giving false statements or information can be grounds for termination of Section 8 Housing Voucher Program assistance and for punishment under state and federal laws. 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. **If there are any changes in income, expenses, and/or household composition prior to my reexamination effective date and which are different than what I reported on this reexamination questionnaire, I understand that I am required to notify the RAA prior to the effective date of reexamination.** I understand that these changes will affect my rent determination.

_____ _____
Signature of Head of Household Date