EQUAL HOUSING OPPORTUNITY

# THE HOUSING AUTHORITY OF THE CITY OF PLYMOUTH WISCONSIN

## APPLICATION FORM

**Personal Information**:

1. Name_____
   SSN:_____ Date of Birth:_____
   Telephone(H)_____(W)_____(C)_____
   Address_____

2. Name_____
   SSN:_____ Date of Birth:_____
   Telephone(H)_____(W)_____(C)_____
   Address_____

**Emergency Contact Information**:

1. Name_____ Relationship_____
   Telephone(H)_____(W)_____(C)_____
   Address_____

**Involuntarily Displaced**:
Are you forced to move due to: Fire:___Flooding:___Tornado:___Homeless:___Other:____

**Placement Consideration**: Pet: Yes_____ No_____ Type_____
Smoker: Yes_____ No_____

**Previous Landlord:**(If desired, put additional landlords on the back of this page)
Agency_____Landlord_____
Phone #_____ Address_____

**Reference**:(If desired, put additional references on the back of this page)
Name_____Phone_____

**Disabled/Handicapped**:
Yes_____ No_____Condition(s)_____

**Previous Convictions**:
Yes_____ No_____ If yes, write explanation on the back of this form.

**INCOME VERIFICATION**

List all incomes of all people who are applying for housing. Income amounts will be verified before admission. Income will also be cross-referenced via HUD with the IRS, Social Security Department, banks, etc., at a later date. Inaccuracies will be penalized.

| | Month | Year |
|---|---|---|
| • Social Security | _____ | _____ |
| • Supplemental Security Income | _____ | _____ |
| • Pension | _____ | _____ |
| • Veterans Benefits | _____ | _____ |
| • Wages | _____ | _____ |
| • Dividends | _____ | _____ |
| • Annuities | _____ | _____ |
| • Interest | _____ | _____ |
| • Rental Income | _____ | _____ |
| • Real Estate | _____ | _____ |
| • IRA Income | _____ | _____ |
| • Alimony | _____ | _____ |
| • Welfare | _____ | _____ |
| • Disability | _____ | _____ |
| • Death Benefits | _____ | _____ |
| • Business | _____ | _____ |
| • Loan to others | _____ | _____ |

**MEDICAL DEDUCTIONS**

Each applicant receives a $400 elderly and/or disability allowance towards their rental deductions. This credit includes, but is not limited to, such items as band-aids, antacids, aspirins, small co-payments, smaller medical bills, and other over the counter items. Do not include these below. Also, do not include bills paid by Medicare, Medicaid, Medical Assistance, insurance companies, etc.

| | Month | Year |
|---|---|---|
| • Medicare Premium | _____ | _____ |
| • Prescription Medication | _____ | _____ |
| • Medical Bills | _____ | _____ |
| • Dental Bills | _____ | _____ |
| • Eye Care/Ear Care | _____ | _____ |
| • Supplemental Ins. Premium | _____ | _____ |
| • Chiropractor | _____ | _____ |

Signature_____ Date_____