

PINE RIDGE APARTMENTS
 316 PINE STREET
 MARQUETTE, MI 49855
 906-226-7559
 906-226-8633 (FAX)



LAKE SUPERIOR VILLAGE
 125 DOBSON PLACE
 MARQUETTE, MI 49855
 906-225-1900
 906-225-0503 (FAX)

Income/Asset Questionnaire

E-mail Address: _____

Phone Number: _____

List all Household Members:

| Household Member | Relation-ship to Head of House | Sex | Birth Date | Disabled |
|------------------|--------------------------------|-----|------------|----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Income, Asset, and Deductions – Pleas answer all questions

| A. Income: | Yes | No |
|--|------------|-----------|
| Are you or any other members of the household currently receiving income from any of the following sources? **Please bring in verification of income. | | |
| Employment/Self-Employment (**You must bring in 2 recent paystubs.) Job #1 _____ Phone _____ Tenant _____ Job #2 _____ Phone _____ Tenant _____ | | |
| Tips, bonuses or commissions, or overtime pay | | |
| Social Security Monthly Amount _____ | | |
| Social Security Disability/SSI Monthly Amount _____ | | |
| Unemployment Weekly Amount _____ State _____ | | |
| Public Assistance/Cash Assistance/State Aid (Food Stamps, State Disability, etc.) Cash Amount _____ Food Amount _____ Caseworker _____ | | |
| Child Support Monthly Amount _____ County/State _____ | | |
| Scholarships or Educational Grants | | |
| Tribal Per Capita Payments | | |
| Child Care Reimbursement (children 13 and under) | | |
| Military Pay | | |
| Workman's Compensation | | |
| Pensions/Retirement Funds | | |
| Alimony | | |
| Wages earned through a government program such as Senior Aides or AmeriCorps. If yes, which program? _____ | | |
| Have you or any other members of the household received any lump sum payments, such as: Inheritance _____ | | |

| A. Income: | Yes | No |
|--|------------|-----------|
| Lottery Winnings _____ Insurance Settlements _____ Other _____ | | |
| Regular Recurring Contributions from Persons or Agencies/outside of household | | |
| Death Benefits | | |
| Income from Rent or Sale of Property | | |
| Annuities or Non-Revocable Trust | | |
| Severance Pay | | |
| Zero Income (No source of income) | | |
| Did you or any other members of the household file a federal tax return last year? | | |
| Are there any adult members of the household (18 years of age or older) receiving income not listed above? Please Specify _____ | | |
| Is your family receiving any type of family contribution or help with bills from family members? If yes, please specify _____ | | |

| B. Assets: | Yes | No |
|---|------------|-----------|
| Do you or any other members of the household have any of the following: | | |
| Checking Accounts Bank _____ | | |
| Savings Accounts Bank _____ | | |
| Certificates of Deposit | | |
| Money Market Funds | | |
| IRA/Keogh Account | | |
| Stocks | | |
| Trust Funds If yes, is the Trust irrevocable? | | |
| Real Estate | | |
| Whole Life or Universal Life Insurance Policy | | |
| Have you or any other household members disposed of any asset(s) for less than fair market value in the past two (2) years? If yes, please list: _____ | | |
| Do you or any other household members have any assets that are held jointly with another person? | | |
| Other (Please List): _____ | | |

| C. Deductions: | Yes | No |
|---|------------|-----------|
| Are there any fulltime students 18 years of age or older in the household? | | |
| Is any household member elderly (age 62 or older) or a person with disabilities? | | |
| Do you have medical expenses that are not paid for by an outside source such as insurance? (Prescriptions, Doctor Appointments, Medical Treatments) Pharmacy _____ Physician _____ | a. | b. |
| Do you have disability expenses that are not paid for by an outside source? | | |
| If yes, is this service necessary to enable a family member (including the member with a disability) to be employed? | | |
| Do you have attendant care expenses? | | |
| If yes, is this service necessary to enable a family member (including the member with a disability) to be employed? | | |
| Do you currently pay for childcare services for any children under the age of 13 residing in your household? Provider _____ Phone _____ | | |
| If yes, is this service necessary in order for you to be employed or to attend school? | | |

| D. Eligibility: | Yes | No |
|------------------------|------------|-----------|
| | | |

| D. Eligibility: | Yes | No |
|--|------------|-----------|
| I have a family member who is absent from the home due to: | | |
| Employment | | |
| Military Service | | |
| Placement in Foster Care | | |
| Temporarily in Nursing Home or Hospital | | |
| Away at School | | |
| Other: _____ | | |
| Are there any sex offenders in your household? | | |
| Expected changes in household: | | |
| Birth of a child (Please provide due date): _____ | | |
| Adopting a Child(ren) on: _____ | | |
| Obtaining Custody of a Child(ren) on: _____ | | |
| Obtaining Joint Custody of a Child(ren) on: _____ | | |
| Receiving a Foster Child(ren) on: _____ | | |

E. Certification – Please Read – Very Important!

I certify that the above information is a complete and true statement of family composition, income, employment, and assets to the best of my knowledge and belief. I know that I am required to cooperate in supplying all information needed to determine my eligibility, level of benefits, or verify my true circumstances. I have no objections to inquiries being made for purpose of verification. I know I am required to report immediately in writing all changes in income and any changes in the household size, when a person moves in or out of the unit. I understand the rules regarding guests/visitors and when I must report anyone who is staying with me. I certify the house or apartment will be my principle residence and that I will not obtain duplicate Federal housing assistance while I am in this current program. I will not sublease my assisted residence. I understand that knowingly supplying false, incomplete or inaccurate information is punishable under Federal or State law. I understand that knowingly supplying false, incomplete, or inaccurate information is grounds for termination of housing assistance.

 Print Name Head of Household

 Signature of Head of Household Date

 Print Name Co-Head

 Signature of Spouse/Co-Head Date

 Print Name Other Family Member Over Age 18

 Signature of Other Family Member Over Age 18 Date