

**OAK PARK HOUSING AUTHORITY  
21 SOUTH BLVD.  
OAK PARK, IL 60302  
(708) 386-9322**

**PERSONAL DECLARATION**

THIS FORM MUST BE COMPLETED IN YOUR OWN HANDWRITING. YOU MUST USE THE CORRECT LEGAL NAME FOR EACH MEMBER OF YOUR HOUSEHOLD. PLEASE PRINT IN PEN. ALL ADULT HOUSEHOLD MEMBERS MUST SIGN ON PAGE 4 OF 4, CERTIFYING THE INFORMATION PERTAINING TO THEM IS TRUE, COMPLETE AND CORRECT. IF THE SPACES PROVIDE ARE NOT ADEQUATE, PLEASE ATTACH THE ADDITIONAL INFORMATION TO THIS FORM.

**Write "N/A" (NOT APPLICABLE) if it does not apply. DO NOT LEAVE BLANKS**

**WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES GOVERNMENT.**

**HEAD OF HOUSEHOLD INFORMATION**

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ Apt.# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

**I. HOUSEHOLD COMPOSITION: List all persons who will be living in your home, listing head of household first. Write N/A (NOT APPLICABLE) if it does not apply.**

HOUSEHOLD MEMBERS	DATE OF BIRTH	RELATIONSHIP TO THE HEAD OF HOUSEHOLD	SOCIAL SECURITY NUMBER	ATTENDING SCHOOL NAME OF THE SCHOOL	INDICATE IF: SINGLE (S) MARRIED (M) SEPARATED (SP) DIVORCED (D)
1.		<b>HEAD</b>			
2.					
3.					
4.					
5.					
6.					
7.					
8.					

**A. If separated or divorced, list the name and address of spouse/ex-spouse as follows:**

NAME \_\_\_\_\_ STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SS NO. \_\_\_\_\_

**B. Absent Parent information [the mother/father of your child(ren)]:**

NAME \_\_\_\_\_ STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SS NO. \_\_\_\_\_

**II. TOTAL HOUSEHOLD INCOME: List all money earned or received by everyone living in your household. This includes money from wages, self-employment, child support, regular gifts, earned income, contributions, Social Security,**

disability payments, SSI, Worker's Compensation, retirement benefits, TANF, Veterans benefits, rental property income, stock dividends, income from bank accounts, alimony, and all other sources. **WRITE "N/A" IF IT DOES NOT APPLY.**

**LIST AMOUNT RECEIVED BELOW:**

NAME OF HOUSEHOLD MEMBER	EMPLOYER NAME & ADDRESS	WEEKLY GROSS WAGES	MONTHLY SELF EMPLOYMENT
1. Job Description: _____	Date of hire: _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone #: _____	\$ _____	\$ _____
2. Job Description: _____	Date of hire: _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone #: _____	\$ _____	\$ _____
3. Job Description: _____	Date of hire: _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone #: _____	\$ _____	\$ _____

**FOR ANY HOUSEHOLD MEMBER:**

NAME OF HOUSEHOLD MEMBER	MONTHLY TANF, GA, OTHER CASE NUMBER: # _____	MONTHLY ALIMONY, CHILD SUPPORT, OTHER	MONTHLY SS, SSI, OTHER BENEFITS	WEEKLY UNEMPLYMNT and/or WORKMANS COMP.	MONTHLY PENSION, DISABILITY & ALL OTHER INCOME
1. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**III. ASSETS: FOR ANY FAMILY MEMBER**

	BANK OR FINANCIAL INSTITUTION	ACCOUNT NUMBER	AMOUNT
CHECKING (S)	_____	_____	\$ _____ \$ _____
SAVINGS	_____	_____	\$ _____ \$ _____
MONEY MARKET ACCOUNT (S)	_____	_____	\$ _____
CREDIT UNION	_____	_____	\$ _____
CERTIFICATES OF DEPOSIT	_____	_____	\$ _____
REVOCABLE TRUSTS	_____	_____	\$ _____
PENSION OR IRA	_____	_____	\$ _____
STOCKS/BONDS	COMPANY _____	NO. OF SHARES _____	\$ VALUE _____
CASH VALUE OF LIFE INSURANCE	_____	_____	\$ _____

**III. ASSETS CONTINUED (WRITE NA IF IT DOES NOT APPLY)**

DO YOU OWN REAL ESTATE? [ ] NO [ ] YES CURRENT MARKET VALUE \$ \_\_\_\_\_

ADDRESS OF PROPERTY \_\_\_\_\_

**IV. ALLOWANCES:**

1. **MEDICAL:** Complete only if the Head of Household or spouse is elderly (age 62 or over) or handicapped or disabled. List all Medical Insurance (not Life Insurance):

<u>Company</u>	<u>Cost Per Month</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Anticipated regular cost of Doctor or Dentist, refilled prescriptions, eyeglasses, hearing aids, transportation, etc., **not covered** by Insurance, Medicare or Medicaid: (Submit proof, such as letter from Doctor or Pharmacy computer print-out.).

_____	_____
_____	_____
_____	_____
_____	_____

2. **CHILD CARE:** Complete only for care of children under age 13 **and** if such care is necessary to enable a family member to work or attend school.

Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Your cost per week: \$ \_\_\_\_\_ (School Term) \_\_\_\_\_ Hours: \_\_\_\_\_

Your cost per week: \$ \_\_\_\_\_ (Summer) \_\_\_\_\_ Hours: \_\_\_\_\_

Does any agency, organization or person pay the cost of childcare? [ ] NO [ ] YES

If yes, state name, address of agency/organization/person: \_\_\_\_\_

Amount paid by agency/organization: School Term \_\_\_\_\_ per week Summer Term \_\_\_\_\_ per week

3. **HANDICAP ASSISTANCE:** If such care is necessary to enable a family member to work or attend school.

Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Your cost per week: \$ \_\_\_\_\_ (School Term) \_\_\_\_\_ Hours: \_\_\_\_\_

Your cost per week: \$ \_\_\_\_\_ (Summer) \_\_\_\_\_ Hours: \_\_\_\_\_

Does any agency, organization or person pay the cost of childcare? [ ] NO [ ] YES

If yes, state name of agency/organization/person: \_\_\_\_\_

Amount paid by agency/organization \_\_\_\_\_

School term per week \_\_\_\_\_ Summer term per week \_\_\_\_\_

V. **DO YOU OWN A CAR?** [ ] NO [ ] YES License Plate # \_\_\_\_\_

MODEL: \_\_\_\_\_ YEAR: \_\_\_\_\_

**SECOND CAR** [ ] NO [ ] YES License Plate # \_\_\_\_\_

MODEL: \_\_\_\_\_ YEAR: \_\_\_\_\_

VI. Nearest relative or friend locally, at a different address. You **must** list someone (in case of an emergency):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**VII. Additional Information:**

1. Did anyone in your household file a federal income tax return for the last tax period?  
 NO       YES If yes, Name of Person(s): \_\_\_\_\_  
 \_\_\_\_\_  
 If YES, were all of the household members listed on the income tax return?  NO     YES  
 If NO, please explain. \_\_\_\_\_
  
2. Did you or anyone in your household claim anyone on the income tax return who is not a household member?  
 NO       YES If yes, Name of Person(s): \_\_\_\_\_
  
3. Does anyone outside of your household claim anyone in your household on their federal income tax return?  
 NO       YES If yes, please explain below.  
 \_\_\_\_\_
  
4. Does anyone outside of your household pay for any of your bills or give you money?  
 NO       YES If yes, please explain below.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. Have you or any other adult members ever used any name (s) or Social Security number (s) other than the one you are currently using?     NO       YES If yes, please explain below.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
6. Have you or any household member lived in any assisted housing?  
 NO       YES If yes, list where and when below.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
7. Have you or anyone in your household ever been arrested or convicted of any crime other than a traffic violation?  
 NO       YES If yes, please explain below.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
8. Have you ever committed any fraud in a Federally assisted housing program or been requested to repay money for misrepresenting information for such housing programs?  
 NO       YES If yes, please explain below.  
 \_\_\_\_\_  
 \_\_\_\_\_

**I do hereby swear and attest that all of the information above is true, complete and correct. I also understand that all increases in the income of any member of the household as well as any changes in the household members must be reported to the Oak Park Housing Authority in WRITING IMMEDIATELY.**

SIGNATURE OF HEAD OF HOUSEHOLD	DATE	SIGNATURE OF SPOUSE	DATE
SIGNATURE OF OTHER ADULT	DATE	SIGNATURE OF OTHER ADULT	DATE

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**To be completed if prepared by person other than the Voucher holder.**

I attest, under penalty of perjury, that the above was prepared by me at the request of the named individual and is based on all information of which I have any knowledge. My relationship to the applicant/certificate holder is \_\_\_\_\_.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Signature: \_\_\_\_\_