Gastonia Housing Authority
Application for Housing Assistance

Do NOT attach any documents or verifications at this time.

Copies of this application are also available for download at www.ghanc.org. Completed applications can be scanned and emailed to hcvadmissions@ghanc.org, mailed to PO Box 2398, Gastonia, NC 28053 or put in the secured drop box in front of our office at 340 W. Long Ave. Gastonia, NC 28052

Please complete all sections and questions using blue or black ink. Incomplete applications will not be processed, and you will not be notified. If your application is not accepted, you will receive an Ineligibility letter explaining why within 4 weeks. If your application is accepted, you will receive an Eligibility Letter. The Eligibility letter does NOT mean you have been approved for housing assistance. It only means that you have been determined initially eligible based on the information on the application form. Final eligibility will not be determined until after your name reaches the top of the waiting list.

After you receive an Eligibility Letter you can use our automated waiting list telephone number **704-675-7677** to check your position on the waiting list. Listen to the prompts and follow instructions to enter your information. Please do not call GHA staff regrading application status. Please keep in mind that it is normal for your position on the waiting list to change as new applications are added and ineligible applications are dropped.

All changes to your household income and household composition (who will live in your household) must be reported in writing within 14 days. You will be notified by mail when your name reaches the top of the waiting list. Please notify us in writing if your current mailing address changes so we can reach you. If we are unable to reach you by mail, your application will be dropped, and you will need to reapply once the waiting list re-opens.

If you are a person with a disability and need assistance completing this application, please email us at the address above or leave a message at 704-349-5149.

Programs you are applying for:

_____ Section 8 Housing Choice voucher program

_____ RAD Family Site (Cameron Weldon / Mt View)

_____ RAD Linwood Terrace (must be 62 or older)

_____ Dallas High School (62 & older or 55 & older AND disabled)

_____ Loftin (62 & older or 55 & older AND disabled)

_____ Gaston Residential Services Second Ave and Kimbrell apartments (must be intellectually or developmentally disabled AND in need of the supportive services provided at the property to live semi-independently)

Name of Head of Household (Last, First, MI) _____

Street Address_____ City, State, Zip Code_____

Mailing Address_____ City, State, Zip Code_____

Phone number where you can be reached or where we can leave a message _____

Email address: _____

Head of Household Marital Status: □ **Single** □ **Married** □ **Separated (legally)** □ **Divorced** □ **Widowed**

Veteran Status: Are you or any member of your household a current military serviceperson or a veteran who has been separated under honorable conditions from any branch of the US armed forces, or the surviving spouse of a veteran? YES / NO If yes, list family member and military status: _____

Accessibility:
Does your household include a disabled person that requires a mobility accessible unit (Ex. wheelchair)? YES / NO.
Does your household include a disabled person that requires a hearing or visual accessible unit (Ex. wheelchair)? YES / NO.

Beginning with you, list all persons who will live in the unit, including foster children, live-in aides (if needed for the care of a family member). Each box must be completed for each family member. ***No one except those listed on this form may live in the unit.***

	First & Last Name	Date of Birth	Sex	Race	Ethnicity Hispanic Y or N	Social Security Number	Relation to Head of House-hold	Disabled Person? Yes or No	Full-time Student Yes or No
H							SELF		
2									
3									
4									
5									
6									
7									
8									
9									

Please list the source and amount of all employment income expected for the next 12 months for <u>each</u> family member, including yourself.

Family Member Name	Employment Income Source	Hourly Rate $	Hours Per Week	Average Pay Amount $	Frequency - Per
					□ **Week** □ **Month** □ **Year**
					□ **Week** □ **Month** □ **Year**
					□ **Week** □ **Month** □ **Year**

Are you self-employed or do you perform any contract work, side jobs, or gig jobs (cutting grass, handyman/ woman, doing hair, Uber, Lyft, Uber Eats, Door Dash, Instacart, etc.)

If yes, type of work and average weekly earnings?: _____

_____

<u>Income Sources</u>	**<u>Yes</u>**	**<u>No</u>**	**<u>Person Receiving</u>**	**<u>Monthly Amount</u>**
• TANF/WFFA	□	□		
• Unemployment Benefits	□	□		
• Workers Compensation	□	□		
• Child Support (attach 12-month printout)	□	□		
• Spousal Support/Alimony	□	□		
• Social Security	□	□		
• SSI	□	□		
• Pension/Retirement	□	□		
• Veteran's Benefits	□	□		
• Self-employment	□	□		
• Food Stamps	□	□		
• Other (explain)	□	□		

- Do you have a court order(s) for child support? YES / NO If yes, attach a copy of the court order

Does anyone outside your household pay for any bills or give you money? □ YES □ NO
If yes, give name and address _____

Amount and frequency _____

Expenses / Deductions:

-Childcare: Does any household member pay out-of-pocket childcare expense for a child age 12 or under? YES / NO If yes, list name, address and phone # of childcare provider: _____

_____

Is there any other household member who could care for this child? YES / NO

Do you have a DSS childcare voucher? YES / NO If yes, please attach a copy.

Disability Expenses: Do you pay for a care attendant or for any equipment for any household member with disabilities that it is necessary to permit that person or someone else in the household to work? YES / NO If yes, are any of these expenses reimbursed by any person or agency? YES / NO

Medical Expenses: (Only applicable to household whose head or spouse is 62 years of age or older or whose head or spouse is a person with a disability).

Does any household member pay for Medicare? YES / NO If yes, list amount: _____

Does any household member pay for any type of medical insurance? YES / NO If yes, list insurance company and amount _____

Does any household member anticipate any medical expenses that will exceed 3% of gross annual income during the next 12 months that will not be reimbursed by or paid for by any source outside of the household (This includes prescription and non-prescription drugs and other medical costs)? YES / NO If yes, list name and address of doctor and/or pharmacy (Attach extra sheet if needed):_____

_____

Criminal History: Have you or any member of your household ever been arrested, charged or convicted for drug-related criminal activity or any criminal act that has as one of its elements the use, attempted use or threatened use of physical force against a person or property of another? YES/NO If yes, list who and explain charges. Please include felonies as well as misdemeanors.

_____

_____

I do hereby swear and attest that all of the information above about me and my family are true and correct. I also understand that all changes in the income of any member of the household as well as any changes in the household members / composition must be reported to the Housing Authority IN WRITING within 14 days.

**By signing this form, I/We recognize that the Lessor or his agent may investigate the information supplied by the applicant, and disclosures of pertinent facts may be made to the lessor.

**Warning: 18 U.S.C 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000 or imprisoned for not more than five (5) years or both.

****I understand that all notifications are through the mail. If I do not respond or the mail cannot be delivered to the address given, my application will be deleted from the waiting list.**

_____

Applicant's Signature **Date**

_____

Co-Applicant's Signature **Date**