

1276 River Street, Suite 300
Boise, Idaho 83702-7049
Phone (208) 345-4907
Fax (208) 345-4909

EXECUTIVE DIRECTOR
DEANNA L. WATSON

DOCUMENT LIST

Interim Change Report for Income, Assets, or Expenses

Remember you are required to report all increases in your household income within 10 days of the occurrence.

If you are reporting a change in your income, assets, or expenses you are required to complete the Participant Information Form and attach the supporting documentation for that change only. You do not need to provide documentation that does not apply to your reported change.

I. INCOME

EMPLOYMENT INCOME- For every member of your household that is working, please provide the following:

- ♦ Paystubs – Current & consecutive for the last 60 days
- ♦ Documentation of other types of income such as tips, commissions, etc.
- ♦ For new employment, you must provide a statement from your employer providing the date of hire, average hours worked per week, and hourly rate or salary amount. The statement must be on company letterhead; OR you may provide your employer with our Employment Verification Form that is available on our website at www.bcacha.org or in our office lobby.

TERMINATION OF EMPLOYMENT

- ♦ You must provide a statement from the employer providing the termination date and whether you are eligible for unemployment or not. The statement must be on company letterhead; OR you may provide the employer with our Termination of Employment Form that is available on our website at www.bcacha.org or in our office lobby.

SOCIAL SECURITY / SSI / SSDI

- ♦ If you or a family member have been receiving Social Security, SSI, or SSDI for more than 3 months you are not required to provide an award letter.
- ♦ If you have been receiving this source of income for less than 3 months or the amount you receive has changed (not including COLA) you must provide a copy of a current award letter dated within the last 60 days. If you are unable to provide the document(s), you may request a copy of your award letter by calling 1-800-772-1213 or going to www.ssa.gov.

SELF EMPLOYMENT

- ♦ You must complete a Self-Employment Form to include the income and expenses for the last 12 months. Receipts for expenses must be attached to the form. The form is available online at www.bcacha.org or in our office lobby.
- ♦ You must also provide a copy of your most recent tax return. If you do not have a tax return because it is new employment, please indicate that on the form.

CHILD SUPPORT:

- ♦ If you have an open case with Idaho you do not need to provide a printout
- ♦ If you receive child support from another state, you must provide a printout of the last 12 months
- ♦ If you don't have an open case but receive child support you must provide documentation of the payments received (ex. Notarized statement from the paying parent or copies of checks)



DOCUMENT LIST Continued

UNEMPLOYMENT BENEFITS:

- ♦ If you are currently receiving unemployment, you must provide a printout of the last 12 months. Screenshots will not be accepted.

GIFT CONTRIBUTION

- ♦ You must provide a notarized statement from the person(s) that give you money or pay your bills. This must include the amount they provide/pay on a monthly basis

OTHER INCOME:

- ♦ For all other income sources you must provide documentation from the source stating the monthly amount received. For example, VA pension, Pension, Annuities, Disability Income, Workmen's Compensation, Alimony, etc.

II. ASSETS

BANK STATEMENTS

- ♦ Current bank statements for all accounts for all family members (i.e., Checking, savings, CDs, etc.)

STOCKS/BONDS

- ♦ Current statement indicating value of stock, and dividend amount.

LIFE INSURANCE

- ♦ Cash surrender value only (please attach table of cash value)

III. FULL TIME STUDENT STATUS (including students 18 or older in high school and/or college)

- ♦ Please provide a LETTER from the school's REGISTRAR OFFICE indicating current full time student status (DO NOT provide an acceptance letter, bill, or schedule); and
- ♦ If enrolled in college, please provide a print out of Financial Aid award letter

IV. MEDICAL EXPENSES- If you, your Spouse, or Co-Head are 62 years of age or older, disabled, and you have medical expenses that exceed your insurance coverage, your family may provide documentation of out of pocket medical expenses.

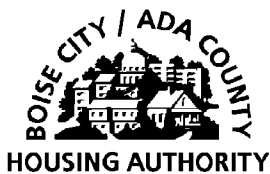
- ♦ For prescription medications you would need to provide a print out of the last 12 months from your pharmacy. Over the counter expenses are not eligible, even if prescribed by a Health Care Provider.
- ♦ If you have outstanding medical bills and you have entered into repayment agreement with a Health Care Provider and are currently making payments, you may provide your Health Care Provider with a Medical Verification Form that is available on our website at www.bcacha.org or in our office lobby.
- ♦ Medical coverage (Only if you pay a premium).

V. CHILD CARE EXPENSES- If you have children 12 years old or younger and you pay for child care to enable a family member to work, actively seek work, or attend school, you may qualify for a child care expense deduction.

- ♦ Provide the name, address, phone number and fax of your child care provider
- ♦ You must provide copies of the last 3 months receipts
- ♦ If applicable, a copy of your most recent ICCP award letter

It is the policy of BCACHA to see that every individual regardless of race, religion, color, sex, age, national origin, familial status, or disability shall have equal opportunity in accessing affordable housing. If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please submit a request in writing or contact our office at (208) 345-4097.





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PARTICIPANT INFORMATION FORM

Are you reporting a change? YES NO If yes, please list change(s) _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY LANGUAGE: _____ TRANSLATION NEEDED? YES NO

Starting on the first line for the Head of Household, please supply the following information for all adults and children that will live in the housing unit to be assisted. List adults first, then children. Enter one of the following codes in box 6 to identify the household relationship of each adult and child listed.

H = Head of Household K = Co-Head (Not Married) Y = Youth Under 18 L = Live-in Aide
S = Spouse (Married) F = Foster Child/Adult E = Full Time Student Over 18 A = Other Adult

| | | | | | | |
|---|---------------|---|------------------|---|-------------------------|---|
| 1. Last Name & Sr, Jr, etc. | 2. First Name | 3. MI | 4. Date of Birth | 5. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 6. Relation H | 7. Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |
| 1. Last Name & Sr, Jr, etc. | 2. First Name | 3. MI | 4. Date of Birth | 5. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 6. Relation | 7. Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |
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| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |
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| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |
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| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |
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| 8. Race (Check One Box) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | 9. Ethnicity (Check One Box) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic | | 10. Social Security Number | | |



INCOME INFORMATION

Check all sources of income received by everyone living in your household. This includes money from wages, self-employment, child support, Social Security, Workman's Compensation, retirement benefits, AABD, Veterans benefits, rental property income, alimony, gift contributions, and all other sources. **You MUST attach current documentation as proof of each source of income. See enclosed Document List.**

- | | | |
|--|---|--|
| <input type="checkbox"/> Employment wages | <input type="checkbox"/> Child Support | <input type="checkbox"/> Retirement benefits |
| <input type="checkbox"/> Self- Employment | <input type="checkbox"/> Alimony | <input type="checkbox"/> Pensions |
| <input type="checkbox"/> Unemployment benefits | <input type="checkbox"/> Social Security | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> SSI or SSDI | <input type="checkbox"/> Veterans pension or benefits | |
| <input type="checkbox"/> AABD payments | <input type="checkbox"/> Gift contributions | |

List all sources and amounts below:

| Household Member | Name of income source / Employer | Monthly Wages | Monthly Child Support | Social Security Benefits | Unemployment Benefits | All other Income (Gifts, Pensions, etc.) |
|------------------|----------------------------------|---------------|-----------------------|--------------------------|-----------------------|--|
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ZERO INCOME CERTIFICATION

Are you or any other adult claiming zero income? Yes No If yes, who: _____

ASSET INFORMATION

Bank Accounts & Other Assets: Check all assets that you or any member of the family has, including checking or savings accounts, savings bonds, stocks, real estate, money market accounts, CDs, etc. **You MUST attach current documentation for each asset. See enclosed Document List.**

| Household Member | Checking Account? | If yes, current balance | Savings Account? | If yes, current balance | Other asset? (CDs, Stocks, Bonds, Annuities, Money Market accounts, retirement accounts, personal property) |
|------------------|---|-------------------------|---|-------------------------|---|
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |



MEDICAL EXPENSE ALLOWANCE

May complete ONLY if the Head of Household, Spouse, or Co-Head is age 62 or older or disabled

If you wish to claim an allowance for your out of pocket Medical Insurance Premiums; Medical, Dental, or Optical Expenses; or Expenses for Prescription Medicines, complete the following. **You MUST attach current documentation for each medical expense in order for it to be included.** Do not list health care providers whose services are covered entirely by insurance, or to whom you do not owe any amount.

| Household Member | Type of Expense | Name of the Provider You Pay for this Expense | Amount You paid/pay "Out of Pocket" |
|------------------|--|--|-------------------------------------|
| | <input type="checkbox"/> Doctor/Dental/Hospital <input type="checkbox"/> Medications <input type="checkbox"/> Insurance Premium <input type="checkbox"/> Other: | | |
| | <input type="checkbox"/> Doctor/Dental/Hospital <input type="checkbox"/> Medications <input type="checkbox"/> Insurance Premium <input type="checkbox"/> Other: | | |
| | <input type="checkbox"/> Doctor/Dental/Hospital <input type="checkbox"/> Medications <input type="checkbox"/> Insurance Premium <input type="checkbox"/> Other: | | |
| | <input type="checkbox"/> Doctor/Dental/Hospital <input type="checkbox"/> Medications <input type="checkbox"/> Insurance Premium <input type="checkbox"/> Other: | | |

OTHER ALLOWANCE

| Do YOU pay child care for a family member under the age of thirteen (13)? | If yes, what child(ren)? | Child Care Provider Name | Amount you pay |
|--|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

(You must attach acceptable documentation in order for this expense to be included. See enclosed Document List.)

PARTICIPANT CERTIFICATION

All household members 18 or older MUST sign

I certify that all the information provided on this form, including household composition, family income and assets, and allowances is true and complete to the best of my knowledge and belief. I know that I am required to provide supporting documentation in order to verify each source of income, asset, or expense. I understand that if I don't provide adequate documentation, the expenses will not be included and/or my housing assistance may be terminated. I understand that false statements or information is punishable under Federal Law.

Head of Household Signature

Date

Spouse / Co-Head / Other Adult Signature

Date

Other Adult Member Signature

Date

Other Adult Member Signature

Date

Other Adult Member Signature

Date

