HOUSING SERVICES
MID MICHIGAN
"Opening doors for people in our communities"

319 South Cochran, PO Box 746
Charlotte, MI 48813

Phone: (517) 541-1180
Fax: (517) 541-0269
Dial 711 TTY
www.hsmidmichigan.org
csmith@hs-mm.org

Section 8 Deadlines

Applications and Disability Verification forms will be passed out beginning 8:30 a.m., Monday, May 2, 2016, until 5:00 p.m., Friday, May 6, 2016.

Applications must be returned to Housing Services no later than 5:00 p.m., Tuesday, May 24, 2016.

Disability Verification forms must be returned to Housing Services no later than 5:00 p.m., Friday, June 10, 2016.

Housing Services Mid Michigan (HSMM) is open Monday through Friday, from 8:30 a.m. to 5:00 p.m.

Applications and Disability Verification forms returned to HSMM via the U.S. Post Office will not be accepted if the postmark is later than the deadlines given above.

HOUSING SERVICES
MID MICHIGAN
"Opening doors for people in our communities"

319 South Cochran, PO Box746
Charlotte, MI48813

Phone: (517)541-1180
Fax: (517)541-0269
Dial 711TTY
www.hsmidmichigan.org
csmith@hs-mm.org

Housing Choice Voucher Pre-Application

1. Head of Household Information

Name (Last, First, Middle): _____
Last First Middle

Mailing Address: _____

_____
City State Zip Code County

Telephone Number: _____ Alternate Number: _____

2. Family Composition – List anyone who will be living in the unit

Full Name	Relationship	Birth Date	Disabled Yes/No	Student Yes/No	Soc. Security Number	Sex M/F

3. HUD Statistical Purposes Only (Optional)

Check One:

☐ White
☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander

Check One:

☐ Hispanic or Latino
☐ Not-Hispanic or Latino

4. Other Contacts – List two relatives or friends who know how to contact you:

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

5. Criminal History:
Have you or anyone in the household ever been convicted of any crime other than traffic violations? ☐ no ☐ yes If "yes", please explain:

Federal Law prohibits HSMM from providing subsidies to individuals who are currently engaged in illegal drug activity; are fugitive felons or parole violators; have been convicted of producing Methamphetamines on federally assisted housing property; any sex offender required to register with a State program; those engaged in illegal drug or alcohol abuse that threatens the health, safety and peaceful enjoyment of the premises; and anyone evicted from federally assisted housing for drug-related activity within the last 3 years.

6. Disability Statement
In order to qualify for a Housing Choice Voucher from Housing Services Mid Michigan either the head of the household, co-head, or spouse must be permanently disabled as verified by a certified physician or by proof of receipt of SSI or SSDI.

7. Certification by Applicant:
By signing this application, I/we declare that all of my/our responses are true and complete and I/we authorize Housing Services Mid Michigan (HSMM) to verify this information. Any false statement on this application can lead to the rejection of this application or immediate termination of your lease. I/we understand that in order for my/our application to remain current I/we must notify HSMM of any change in address.

Head of Household Signature: _____ Date: _____

Spouse or Co-head Signature: _____ Date: _____

HOUSING SERVICES
MID MICHIGAN
"Opening doors for people in our communities"

319 South Cochran, PO Box746
Charlotte, MI48813

Phone: (517)541-1180
Fax: (517)541-0269
Dial 711TTY
www.hsmidmichigan.org
csmith@hs-mm.org

SECTION 8 MAINSTREAM VOUCHER PROGRAM

REQUEST FOR VERIFICATION OF HANDICAP OR DISABILITY

(Issued under Section 8 of the U.S. Housing (program) Act of 1937,
Failure to comply could result in the termination of benefits.)

LICENSED HEALTH PROFESSIONAL AUTHORIZATION:
You are authorized to release information concerning my handicap or disability to Housing Services Mid Michigan.

Patient's Signature _____ Date _____

Federal law gives special consideration to a person or family of a person who is handicapped or disabled in order to be eligible to receive federally aided housing. For the purpose of qualifying for such special consideration at least one of the heads of the household must:

A. be unable to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment which can be expected to last for a continuous period of not less than 12 months; or

B. in the case of an individual who is 55 years of age and is blind, be unable by reason of blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time; or

C. be a handicapped person which is defined as a person having a physical or mental impairment which:
   1. is expected to be of a long-continued and indefinite duration, and
   2. substantially impedes the ability to live independently, and
   3. is of such a nature that such ability could be improved by more suitable housing conditions.

D. be developmentally disabled which means a severe, chronic disability of a person which:
   1. is attributable to a mental or physical impairment or combination of mental and physical impairments; and
   2. is manifested before the person is 22; and
   3. is likely to continue indefinitely; and
   4. results in substantial functional limitation in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, ability, self-direction, capacity for independent living, and economic self-sufficiency, and reflects the persons need for a combination and sequence of special inter-disciplinary, or generic care, treatment, or other services which are of life-long or extended duration and are individually planed and coordinated.

CERTIFICATION OF HANDICAP OR DISABLITY

Instructions: **Only a health professional licensed by the Bureau of Occupational and Professional Regulation may complete this form.**

In my opinion, _____
(Name of Patient)

☐ is ☐ is not handicapped as defined on the previous page for a long-continued and indefinite duration. An explanation of the nature of the handicap is:

_____
_____
_____

☐ is ☐ is not disabled as defined on the previous page for a continuous period of not less than 12 months. An explanation of the disability is:

_____
_____
_____

☐ This patient is permanently handicapped or disabled.

_____
_____
_____

As a duly licensed health professional, I certify the information given is correct.

_____ _____
Type or Print Name of Health Professional Licensed as a

_____ _____
Signature of Health Professional Date Signed

_____
Street Address City State Zip Code

_(____)_____
Telephone Number

Please mail or fax this form to the above address
Attn: Section 8 Program