



HOUSING SERVICES
M I D M I C H I G A N

"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 711TTY

www.hsmidmichigan.org
csmith@hs-mm.org

Mainstream Voucher Pre-Application

Non-elderly, disabled households only

You must be under 62 at the time of your briefing to qualify.

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

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

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: _____



"HSMM is an equal opportunity provider"





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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 DISABILITY

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
Code

City

State

Zip

_() _____
Telephone Number

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



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