**Mainstream Voucher Pre-Application**

**Non-elderly, disabled households only**

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

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| 1. | | Head of Household Information | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Name (Last, First, Middle): | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | Mailing Address: | | | | | | Last First Middle | | | | | | | | | | | | | | | | | | | |
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|  | |  | | | | |  | | | City | | | | State | | | Zip Code | | | | County | | |  | | | |
|  | | Telephone Number: | | | | | |  | | | | | | | | Alternate Number: | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Family Composition **– List anyone who will be living in the unit INCLUDING YOURSELF** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Full Name | | | | | | | | Relationship | | | | | Birth Date | | | | Disabled  Yes/No | | | Student  Yes/No | Soc. Security Number | | | | | Sex  M/F |
| **Voucher holder** |  |  | | | | | | | |  | | | | |  | | | |  | | |  |  | | | | |  |
|  |  | | | | | | | |  | | | | |  | | | |  | | |  |  | | | | |  |
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|  | | | | | | | |  | | | | |  | | | |  | | |  |  | | | | |  |
| 3 | HUD Statistical Purposes Only (Optional) | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Check One: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | White | | | | | | | | |  | | Asian | | | | | | | | | | | | |
|  |  | | | Black/African American | | | | | | | | |  | | Native Hawaiian/Other Pacific Islander | | | | | | | | | | | | |
|  |  | | | American Indian/Alaska Native | | | | | | | | |  | |  | | | | | | | | | | | | |
|  |  | | |  | | | | | | | |  |  | | |  | | | |  | | | | |  | | |
|  | 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: | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | 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”*

