

# SECTION 811 PROJECT RENTAL ASSISTANCE PROGRAM APPLICATION

**TDHCA Point of Contact:**

[811info@tdhca.state.tx.us](mailto:811info@tdhca.state.tx.us)

**Instructions for completing application**

*Referral Agent: Please assist the applicant to complete the information below. Include information for all persons who plan to live in the Section 811 unit except where otherwise indicated.*

**REFERRAL AGENT INFORMATION**

Contact information for the Referral Agent.

Referral Agent Name: \_\_\_\_\_  
 Agency: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

**APPLICANT CONSENT TO RELEASE INFORMATION**

As an Applicant to the Section 811 Project Rental Assistance Program, I authorize the Referral Agent named above to share the following information with the TDHCA Point of Contact and/or properties selected under Property Options and the TDHCA Point of Contact named above to share following information with properties selected under Property Options: all information used to determine income, assets, allowances, deductions, program eligibility and family composition including, but not limited to income verification including bank statements, Social Security Administration award letters; personal information including birth certificates, Social Security numbers; eligibility information including disability, criminal history, rental history. By signing this form I hereby authorize the release of the requested information.

**APPLICANT INFORMATION**

Head of Household Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone No: \_\_\_\_\_ Alternate Phone No: \_\_\_\_\_  
 Email: \_\_\_\_\_ Medicaid ID No: \_\_\_\_\_

**LIST ALL MEMBERS THAT WILL BE LIVING IN THE HOUSEHOLD**

Will there be a live-in aide in this unit who is not a family member? *Select one*  Yes  No  
 Is the household size expected to increase, e.g. pregnancy, child in other care, etc.? *Select one*  Yes  No

Household Members (List Head of Household first)	DATE OF BIRTH	GENDER	SOCIAL SECURITY #	RELATIONSHIP TO HEAD OF HOUSEHOLD	SPECIAL STATUS	DISABLED?
1.		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed		Head	<input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Displaced <input type="checkbox"/> Joint Custody	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed			<input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Displaced <input type="checkbox"/> Joint Custody	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed			<input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Displaced <input type="checkbox"/> Joint Custody	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed			<input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Displaced <input type="checkbox"/> Joint Custody	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed			<input type="checkbox"/> Student <input type="checkbox"/> Veteran <input type="checkbox"/> Displaced <input type="checkbox"/> Joint Custody	<input type="checkbox"/> YES <input type="checkbox"/> NO

Was any Household member 62 or older as of January 31, 2010, who does not have a SSN, and whose initial determination of eligibility was prior to January 31, 2010?  Yes  No

If yes, who and where?: \_\_\_\_\_

**Important Information for Former Military Services Members.** Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Cost Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information please visit with the Texas Veterans Portal at <https://veterans.portal.texas.gov/>.

HOUSEHOLD MEMBER	LIST ALL STATES IN WHICH THE HOUSEHOLD MEMBER HAS RESIDED
1.	
2.	
3.	
4.	
5.	

**TOTAL HOUSEHOLD INCOME: LIST ALL MONEY EARNED OR RECEIVED BY EVERYONE LIVING IN YOUR HOUSEHOLD.**

HOUSEHOLD MEMBER	EMPLOYER	TOTAL WEEKLY WAGES	TANF	CHILD SUPPORT MONTHLY	SOCIAL SECURITY BENEFITS	IS SS INCOME DUAL ENTITLEMENT?	UNEMPLOYMENT BENEFITS	ALL OTHER INCOME
1.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
2.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
3.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
4.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
5.						<input type="checkbox"/> YES <input type="checkbox"/> NO		

ARE YOU OR ANYONE IN YOUR HOUSEHOLD SELF EMPLOYED?  YES  NO

Have you or any member lived in any assisted housing?  YES  NO

If yes, list where and when \_\_\_\_\_

Do you or any member of your household owe money to a Public Housing Authority?  YES  NO

If yes, please explain: \_\_\_\_\_

**Housing Type-**

- Nursing Facility   
 ICF-ID   
 Homeless   
 Living with Family  
 Youth Residential Treatment Center   
 Other: \_\_\_\_\_

**ASSETS: PLEASE CHECK ALL THAT APPLY**

HOUSEHOLD MEMBER	CHECKING/SAVINGS	REAL ESTATE	LIFE INSURANCE	STOCKS/BONDS	IRA/KEOGH	MONEY MARKET	PERSONAL PROPERTY
1.	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
2.	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
3.	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
4.	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
5.	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$

# TARGET POPULATION

In order to be eligible, at least one member of the applicant household must qualify for one of the three target populations. Complete the checklist below to determine whether the applicant qualifies.

Name of household member: \_\_\_\_\_

Instructions: Check one box in Column A and then check boxes in corresponding Column B to describe the household member’s qualifications. Note: If there is a second member of the household who is a member of a target population, complete a new check list for that member.

Column A	Column B
<input type="checkbox"/> Persons with Disabilities Exiting ICF/IIDs and Nursing Facilities	<p>Applicant must be eligible for one of the following waivers. Check at least one:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> STAR+PLUS Waiver Services</li> <li><input type="checkbox"/> Home and Community-based (HCS) Waiver Services</li> <li><input type="checkbox"/> Community Living and Support Services (CLASS) Waiver Services</li> <li><input type="checkbox"/> Texas Home Living (TxHmL) Waiver Services</li> <li><input type="checkbox"/> Deaf, Blind with Multiple Disabilities (DBMD) Waiver Services</li> <li><input type="checkbox"/> Medically Dependent Children Program</li> <li><input type="checkbox"/> Community First Choice</li> <li><input type="checkbox"/> Attendant Services paid through Medicaid or Title XX</li> </ul> <p>Applicants exiting institutions must also meet all of the following 3 requirements. Check all 3 boxes to confirm the applicant meets these.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Applicant is eligible to receive services paid through Medicaid; and</li> <li><input type="checkbox"/> Applicant household<sup>1</sup> has income that does not exceed 300 percent of SSI or income limits established through the Medicaid Buy-In Program for Workers with Disabilities (250 percent of the federal poverty level); and</li> <li><input type="checkbox"/> Applicant meets the Nursing Facility or ICF/IID Medical Level of Care requirement.</li> </ul>
<input type="checkbox"/> Persons with Serious Mental Illness.	<p>Applicant must meet both of the following requirements. Check both boxes to confirm the applicant meets these requirements.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Applicant is eligible for the Medicaid State Plan Services provided through HHSC Local Mental Health Authorities or Local Behavioral Health Authorities. These services include psychosocial rehabilitation and targeted case management.</li> <li><input type="checkbox"/> Applicant is eligible to receive disability-related Medicaid (e.g. Supplemental Security Income (SSI)) at the time of first occupancy.</li> </ul>
<input type="checkbox"/> Youth Exiting Foster Care	<p>Applicant is eligible to receive health care services through Texas Medicaid by virtue of (check one box):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Being in DFPS conservatorship; or</li> <li><input type="checkbox"/> Being a youth aged 18-21 who was previously in DFPS conservatorship and receives Medicaid for Transitioning Foster Care Youth (MTFCY) (now called Former Foster Care Children Program) benefits. With very few exceptions, all children and youth in DFPS conservatorship and those youth who are eligible for MTFCY benefits receive their healthcare through the STAR Health managed care program, a comprehensive health care system that is offered statewide.</li> </ul> <p>Applicant must also meet the following requirement. Check the box to confirm the applicant meets this requirement.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Applicant is eligible to receive disability-related Medicaid (e.g. Supplemental Security Income (SSI)) at the time of first occupancy.</li> </ul>

\_\_\_\_\_  
Signature of Appropriate Professional

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

<sup>1</sup> Applicant Household are all persons who will reside in the household with the exception of any paid live-in aide.



## HOUSING NEEDS

### Accessibility Needs

A household member needs a unit that (check all that apply)

- Has no stairs
- Has a ramp
- Has access in unit to accommodate wheelchair
- Has access for visual disability
- Has access for hearing disability
- Other. Please describe: \_\_\_\_\_

## CRIMINAL HISTORY

Have you or any member been evicted in the last three years from federally assisted housing for drug-related criminal activity?

YES  NO

If yes, has the household member has successfully completed an approved, supervised drug rehabilitation program?

YES  NO  N/A

If yes, list where and when \_\_\_\_\_

If yes, do circumstances leading to the eviction no longer exist?

YES  NO  N/A

If yes, please explain: \_\_\_\_\_

Are you or any member currently engaged in illegal use of drugs or pattern of illegal use of a drug that may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents?

YES  NO

Are you or any member subject to a State sex offender lifetime registration requirement?

YES  NO

Are you or any member currently engaged in a pattern of abuse of alcohol that may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents?

YES  NO

## VOLUNTARY SERVICES STATEMENT

By signing and submitting this form, the resident understands that the receipt of services is voluntary and not required for residency in a Section 811 unit.

**WARNING: TITLE 18, SECTION 1001 OF THE U.S. CODE STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OF THE UNITED STATES GOVERNMENT. HUD AND ANY OWNER (OR ANY EMPLOYEE OF HUD OR THE OWNER) MAY BE SUBJECT TO PENALTIES FOR UNAUTHORIZED DISCLOSURES OR IMPROPER USE OF INFORMATION COLLECTED BASED ON THE CONSENT FORM. USE OF THE INFORMATION COLLECTED BASED ON THIS VERIFICATION FORM IS RESTRICTED TO THE PURPOSES CITED ABOVE. ANY PERSON WHO KNOWINGLY OR WILLINGLY REQUESTS, OBTAINS OR DISCLOSES ANY INFORMATION UNDER FALSE PRETENSES CONCERNING AN APPLICANT OR PARTICIPANT MAY BE SUBJECT TO A MISDEMEANOR AND FINED NOT MORE THAN \$5,000. ANY APPLICANT OR PARTICIPANT AFFECTED BY NEGLIGENT DISCLOSURE OF INFORMATION MAY BRING CIVIL ACTION FOR DAMAGES, AND SEEK OTHER RELIEF, AS MAY BE APPROPRIATE, AGAINST THE OFFICER OR EMPLOYEE OF HUD OR THE OWNER RESPONSIBLE FOR THE UNAUTHORIZED DISCLOSURE OR IMPROPER USE. PENALTY PROVISIONS FOR MISUSING THE SOCIAL SECURITY NUMBER ARE CONTAINED IN THE SOCIAL SECURITY ACT AT 208 (A) (6), (7) AND (8). VIOLATION OF THESE PROVISIONS ARE CITED AS VIOLATIONS OF 42 U.S.C. 408 (A) (6), (7) AND (8).**

- I understand the unit I am applying for will be my only residence.
- I agree to pay the rent required by the program under which I will receive assistance.
- I have received a copy of the Resident Rights and Responsibilities Brochure.
- I have received a copy of the HUD Fact Sheet "How Your Rent is Determined".
- I have received a copy of the EIV & You Brochure.

**I understand that during the property application phase, if I do not return required documents to the property in accordance with property policies regarding timely receipt of documents I may be skipped or removed from the waitlist entirely.**

**I do hereby swear and attest that all of the information above about me is true and correct.**

\_\_\_\_\_  
Signature Head of Household

\_\_\_\_\_  
Date

