HOUSING AUTHORITY OF BREVARD COUNTY

SECTION 8 HOUSING CHOICE VOUCHER PROGRAM
1401 Guava Avenue, Melbourne, FL 32935
Phone (321) 775-1592 * Fax (321) 775-1549
http://www.habc.us

CHIEF EXECUTIVE OFFICER

Michael L. Bean

INTERIM CHANGE REPORT FORM

Dear Client:

The following information is needed ONLY if there has been a change in your address, family composition, income, current housing or living arrangements.

If you are a current Section 8 participant, **it is your responsibility to report all changes in family size and income to the Housing Authority, in writing, within ten (10) days of the date the change occurred**, according to your Housing Voucher and Housing Authority of Brevard County's Administration Plan.

Failure to do so could result in the termination of your Section 8 assistance. If the information has not been reported timely, an overpayment may have occurred and you may be required to reimburse the Housing Authority.

PLEASE PRINT and complete entire forms (front and back).

Client Name _____ Social Security Number _____

Current Address _____

Phone Number _____ Email Address _____

Check the box that applies to your Interim Change

☐ **INCOME** **(*Please check a box and explain your change below*)**

☐ NEW JOB	☐ JOB CHANGE	☐ UNEMPLOYMENT
☐ LOSS OF JOB	☐ MORE HOURS	☐ CHILD SUPPORT
☐ LESS HOURS	☐ INCREASE/DECREASE IN PAY	☐ SSI/SOCIAL SECURITY

☐ OTHER – CHANGES IN FAMILY INCOME (EXPLAIN):

_____

_____

_____

Use the Employer Income Verification Form if you are reporting: New Job or Loss of Job

If you are reporting Increase/Decrease of Hours/Pay – Submit the Last 6 Paystubs

If your childcare expenses have changed due to change of employment provide updated child care expense

☐ **CHILD CARE EXPENSE** **(*Please check a box and explain your change below)***

☐ New Child Care Provider ☐ No longer have child care ☐ Increase/Decrease in Fees

Provide verification of any Child Care Expense Change

☐ **HOUSEHOLD COMPOSITION** **(Please check a box and explain your change below)**

☐ Request to Add Member ☐ Request to Remove Member

Name	Relationship	Sex	Age	Social Security Number	Date of Birth

Please indicate the reason why:

_____

_____

_____

_____

_____

All Household Composition Changes must have Add/Remove Family Request Form completed by Client/Tenant and Landlord.

HABC and the landlord must approve all additions to your household PRIOR to them moving in.

You must also provide HABC with a Social Security card, Birth Certificate, and Section 214 Status Form before they will be added to your household.

WARNING:

Section 1001 of Title XVII of the United States Code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the United States as to any matter within its jurisdiction.

I certify that the above information is correct and I understand that any misrepresentation will be grounds for denial or termination with the Section 8 Housing Voucher Program or Public Housing Program.

_____ _____

CLIENT SIGNATURE **DATE**

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INCOME VERIFICATION

THIS FORM MUST BE RETURNED BY EMPLOYER

We are required by law to verify the income of all applicants and tenants in our housing programs. We ask your cooperation in supplying the information requested below. This information will be held in confidence for use only in determining the family eligibility and rent.

COMPANY NAME _____ **ATTN.** _____

COMPANY FAX # _____ **COMPANY PH#** _____

**** I AUTHORIZE THE RELEASE OF THE INFORMATION REQUESTED BY THE HOUSING AUTHORITY ****

_____ _____
APPLICANT / TENANT DATE

NAME_____**SS#**_____ **DATE EMPLOYED**_____

ADDRESS_____**CITY** _____**, FL ZIP** _____

JOB CLASSIFICATION_____ **LAST DATE OF EMPLOYMENT**_____

CURRENT HOURLY RATE$_____ **HOURS WORKED PER WEEK AT BASE RATE** _____

AMOUNT OF OVERTIME PER WEEK_____**HOURLY OVERTIME PAY RATE**_____

PAYDAYS ARE: ☐ WEEKLY ☐ BIWEEKLY ☐ BIMONTHLY ☐ MONTHLY

IF PAID OTHER THAN HOURLY, THE AMOUNT IS: $_____ **PER**_____

****TOTAL EARNED IN PAST TWELVE (12) MONTHS: $**_____

TOTAL EARNED IF LESS THAN TWELVE (12) MONTHS: $_____**FROM**_____**TO**_____

LIST TYPE AND AMOUNT OF ANY ADDITIONAL PAY THAT THE EMPLOYEE RECEIVED SUCH AS BONUSES, TIPS, COMMISIONS ETC._____

ADDITIONAL COMMENTS_____

****

FIRM NAME:_____

ADDRESS: _____

CITY/STATE/ZIP: _____

COMPLETED BY: _____

TITLE: _____ PHONE: _____

DATE COMPLETED: _____

PLEASE RETURN THIS FORM TO:

HOUSING AUTHORITY OF BREVARD COUNTY
SECTION 8 HCV PROGRAM
1401 GUAVA AVENUE
MELBOURNE, FL 32935
(321) 775-1592

PLEASE FAX BACK AS SOON AS POSSIBLE.

321-775-1549

Equal Housing-Equal Employment

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Housing Choice Voucher Program

ADD TO/REMOVE FROM FAMILY COMPOSITION

(Please Print)

Client's Name: _____ Recert Month: _____

Social Security #: _____ Phone #: _____

- ☐ ***I would like to add the following individual/family member(s) to my household***
- ☐ ***I would like to remove the following individual/family member(s) from my household***

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Date of Birth: _____ Date of Birth: _____

Social Security #: _____ Social Security #: _____

Purpose/Reason: _____

_____

Income to be added/removed: _____

Address of new residence (if removing person(s): _____

_____

_____ _____
Client's Signature Date

_____ _____
Landlord's Signature Date

(FORM MUST BE COMPLETED & SIGNED WITH ALL NEEDED DOCUMENTS ATTACHED)