



Park Place
Jenny Towers
Stonebridge

215 Grand Avenue Merrill WI 54452
711 E First Street Merrill WI 54452
307 W Main Street Merrill WI 54452
TTY# 800-947-3529

PH 715-722-1081 Fax 715-804-5045
PH 715-722-1081 Fax 715-539-5433
PH 715-722-1081 Fax 715-722-1083
Website: www.merrillha.com



APPLICANT NAME: _____

Last Name First Name Middle Name

Your application will be verified for eligibility and your name placed on a waiting list based on date and time of completed application. The Merrill Area Housing Authority has a preference for individuals or families that live in the City of Merrill and Lincoln County. You will be contacted when your name reaches the top of the list. I am interested in having my name placed on a waiting list(s) for an apartment at the following complex(es):

**SECTION 8 NEW CONSTRUCTION
ELDERLY/DISABLED (62 and Older or Disabled)**

JENNY TOWERS (ELDERLY & DISABLED): () 1 Bedroom

**SECTION 8 NEW CONSTRUCTION
MULTI-PERSON HOUSING**

DUPLEXES (WOODBINE AVENUE) () 2 Bedroom

HOMES (ST PAUL, MAIN & CALIFORNIA): () 3 Bedroom

**SECTION 8 MULTIFAMILY PBRA
INDIVIDUALS/DISABLED (Age 18 & older)**

PARK PLACE (215 Grand Ave): () 1 Bedroom

STONEBRIDGE (307 W Main St): () 1 Bedroom () 2 Bedroom

WESTGATE (WATER STREET): () 2 Bedroom () 3 Bedroom () 4 Bedroom

Head of Household Signature: _____ Date: _____

Co-Head Signature: _____ Date: _____

**VERIFICATION OF SOCIAL SECURITY CARDS FOR ALL MEMBERS OF THE HOUSEHOLD,
And DRIVERS LICENSE OR STATE ID'S FOR ALL ADULT MEMBERS OF THE HOUSEHOLD,
ARE REQUIRED AT THE TIME YOUR APPLICATION IS PROCESSED**



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MERRILL AREA HOUSING AUTHORITY APPLICATION FOR OCCUPANCY

Head of Household (Member #1): _____ **SS#:** _____

Maiden Name or Other Names Used, etc.: _____

Date of Birth: _____ **Age:** _____ **Sex:** Male Female **Veteran:** Yes No

Race: White Black/African Indian-Ameri/Alas Asian Hispanic Decline

Ethnic: Hispanic Non-Hispanic Decline

Current Employer Name: _____ **Address:** _____

Student: Yes No Full-time Attendance

School Name: _____ **Date of Graduation:** _____

List all states you have resided in: _____

Co-Head of Household (Member #2): _____ **SS#:** _____

Maiden Name or Other Names Used, etc.: _____

Date of Birth: _____ **Age:** _____ **Sex:** Male Female **Veteran:** Yes No

Race: White Black/African Indian-Ameri/Alas Asian Hispanic Decline

Ethnic: Hispanic Non-Hispanic Decline

Current Employer Name: _____ **Address:** _____

Student: Yes No Full-time Attendance

School Name: _____ **Date of Graduation:** _____

List all states you have resided in: _____

Current Address: _____

Mailing Address: _____

Telephone Number: _____ **Cell Phone:** _____

Work Number: _____ **Best time to call:** _____

Emergency contact (Name & Phone Number): _____

Do you currently have any pets: Yes No **Type:** Cat Dog **Weight?** _____

HOUSEHOLD INFORMATION

Please provide the following information for all people that will be living with you in your apartment: All adults (including yourself), children under the age of 18, list how they are related to the head of household for each person, and mark race of each household member.

(W) White (B) Black/African (I) Indian/Alaskan (H) Hispanic (A) Asian (O) Other

<u>Name</u>	<u>SS#</u>	<u>DOB</u>	<u>Sex (M/F)</u>	<u>Veteran Yes/No</u>	<u>Race</u>	<u>Relationship</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Is there any member of the household that is considered a disabled individual? Yes No
If so, who?: _____

DISABLED/HANDICAP INFORMATION

Would any member of your household benefit from a wheelchair adapted/barrier free unit? Yes

Tenants or Co-Tenants which meet the definition of disabled or handicapped qualify for a \$400 deduction to their annual income when determining rent contribution and certain other deductions. See information listed below which defines disabled or handicap.

Do you feel you qualify and would like to request this adjustment to your income? Yes No
If yes, please provide documentation from your physician confirming your qualification for this status. Failure to provide this information may result in the denial of these deductions.

INCOME INFORMATION

List all sources of gross income earned by all individuals living in your household to include:

Income from wages, self-employment, Social Security, disability payments (SSI), retirement or pensions, veteran's benefits, W2, alimony, child support, workman's compensation, unemployment benefits, cash paid jobs, etc.

Household Member	Source of Gross Income	Weekly Hours Worked	Hourly Wage	Monthly Gross Income
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

CHILD SUPPORT

Was child support ordered to be paid? Yes No

If receiving child support, please list name of person pay the support: Be sure to list address where the child support is paid from. If receiving support directly from the payer, indicate their name and address. If receiving support through the court, indicate County Agency name and address.

Name: _____

File Number: # _____

Agency Name: _____

Address: _____

Name: _____

File Number: # _____

Agency Name: _____

Address: _____

CLAIMING ZERO INCOME

Are you receiving help on a regular basis from someone not living in your household to help you pay rent, purchase household/personal items, or pay other bills? If so, complete the following:

Name: _____

Phone Number: # _____

Address: _____

ASSET INFORMATION

(List all information for all individuals residing in household)

Cash on Hand: List Amount on Hand at Present Time: \$ _____
(Include cash in safety deposit boxes, home safes, etc...)

Checking Accounts

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Savings Accounts

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

CD's or IRA's

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Bank Name: _____ \$ _____
Bank Address: _____ Current Balance

Stocks/Bonds

Type: _____ # Owned: _____ Dividend Rate: _____% Value: \$ _____
Type: _____ # Owned: _____ Dividend Rate: _____% Value: \$ _____

Annuities/Trusts

Type: _____ # Owned: _____ Dividend Rate: _____% Value: \$ _____
Type: _____ # Owned: _____ Dividend Rate: _____% Value: \$ _____

REAL ESTATE - Owned at present time or sold within the last 2 years

Type of Property: _____ Market Value \$ _____

If sold within last 2-year period, list amount sold for \$ _____

Is property owned jointly? Yes No If yes, list name of person: _____

Type of Property: _____ Market Value \$ _____

If sold within last 2-year period, list amount sold for \$ _____

Is property owned jointly? Yes No If yes, list name of person: _____

Land Contract Sale

Original land contract amount: \$ _____ Balance due at present time: \$ _____

Terms of Land Contract: \$ _____ Monthly \$ _____ Annual Interest Rate: _____%

All Other Assets Owned (Funeral Trusts with Revocable Interest, Whole Life Ins Policies, etc...)

Type: _____ Name of Bank: _____ Value: \$ _____ Interest Rate _____%

Type: _____ Name of Bank: _____ Value: \$ _____ Interest Rate _____%

MEDICAL EXPENSES (To be completed for Elderly/Disabled households only)

If you or any member of your household is 62 years of age or older; disabled; and if any household member pays for medications, medical/dental treatments, supplemental insurance premiums, or prescriptions which are not reimbursed, list information below:

Medical Expense	Provider Name
Medicare Premium: \$ _____	_____
Prescriptions: \$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____
Medical Bill Pymts: \$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____
Supplemental Ins: \$ _____	_____
Dental Insurance: \$ _____	_____
Vision Insurance: \$ _____	_____
Eyeglasses: \$ _____	_____
Hearing aid: \$ _____	_____

CURRENT HOUSING EXPENSES

_____ Rent \$_____ Monthly for rent \$_____ Monthly Utilities
_____ Own \$_____ Monthly Mortgage \$_____ Monthly Utilities

Present Landlord: _____

Landlord Address: _____

Phone #: _____ # of Bedrooms _____ # of People _____

Are you responsible to pay utilities: Yes No Which utilities? _____

Are you currently delinquent with rent or utilities payment: Yes No

If eviction in process were utilities being disconnected? Yes No

Have you been evicted in the last 3 years? Yes No

CHILDCARE EXPENSES

List amount paid by family for the care of minor children under 13 years of age when such care is necessary to enable a family member to further education or to be gainfully employed.

\$_____ Monthly Childcare Provider's Name: _____

Address: _____ Phone: _____

REFERENCES

Previous Landlord Name: _____

Landlord Address: _____

Landlord Phone: _____

Rental Unit Address: _____

Occupancy Dates: _____

Previous Landlord Name: _____

Landlord Address: _____

Landlord Phone: _____

Rental Unit Address: _____

Occupancy Dates: _____

Has any member of the household rented from the Merrill Area Housing Authority in the past?

Yes or No If yes, occupancy dates: _____

Has any member of the household received any rental assistance in the past" (Section 8 Voucher, NEWCAP, Rural Housing, rental assisted housing with any other housing authority)

CRIMINAL HISTORY

Have you or any member of your household been charged with any felonies? Yes No

If yes, list individual name: _____

List dates, charges, city and state it occurred: _____

Have you or any member of your household been charged with drug related activity? Yes No

If yes, list individual name: _____

List dates, charges, city and state it occurred: _____

Have you or any member of your household required to register as a sex offender? Yes No

If yes, list individual name: _____

Do you currently have any current or outstanding landlord property damages? Yes No

Do you currently have any unpaid rent? Yes No

Do you currently have any unmet utility bills? Yes No

“The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, sex, religion, age, disability, political beliefs, sexual orientation or marital or family status. (Not all prohibited bases apply to all programs) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA’s TARGET center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.”

APPLICANT CERTIFICATION: I understand that the above information is being collected to determine my eligibility and that the information provided will be verified and may be released to appropriate Federal, State or local agencies. I/we certify that the answers and information given on this application are true and complete to the best of my/our knowledge and belief and I/we authorize inquires to be made of pertinent third parties to verify our income and deductions. I/we understand that false statements or information are punishable by fine or imprisonment under Federal and State Law.

In addition to verifying income, assets and other information, a criminal background check is conducted before any applicant is approved.

I also certify that the unit applied for will be my household's permanent residence and I do not/will not maintain a separate subsidized rental unit in a different location.

_____ Applicant's Signature	_____ Social Security #	_____ Date
_____ Co-Applicant's Signature	_____ Social Security #	_____ Date

“The information regarding race, ethnicity, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the Rural Housing Service that the Federal laws prohibiting discrimination against tenant applications on the basis of race, color, national origin, religion, sex, familial status, age, and disability are complied with. You are not required to furnish this information but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, the owner is required to note the race, ethnicity, and sex of individual applicants on the basis of visual observation or surname.
