



Lac du Flambeau Chippewa Housing Authority

554 Chicog Street
 PO Box 187
 Lac du Flambeau, WI 54538
 (715) 588-3348
www.ldfcha.org

Date Received: _____
Time Received: _____
Received By: _____

HOUSING APPLICATION FORM

GENERAL INFORMATION:

Applicant Name: _____ Daytime Phone: (____) ____ - _____

Address: _____ Alternate Phone: (____) ____ - _____

City, State, Zip: _____ Email Address: _____

Emergency Contact: _____ Emergency Phone: (____) ____ - _____

SELECT UNIT SIZE: *(Check each that applies, do not request a unit that has more bedrooms than the number of people in your household)*

1 - 2 Bedrooms
 2 - 3 Bedrooms
 3 - 4 Bedrooms
 5 Bedrooms

	Legal Name (First, Middle Initial, Last)	Relationship to Head of Household	Social Security Number	DOB (Month, Day, Year)	Student		
					YES	or	NO
1		Head of Household	__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>
2			__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>
3			__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>
4			__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>
5			__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>
6			__-__-__	__/__/__	<input type="checkbox"/>		<input type="checkbox"/>

RESIDENT HISTORY: *(Required for NEW tenants only) Please list all housing for the past two (2) years.*

Present Address:			Landlord Name:	
Street:		Own: <input type="checkbox"/>	Address:	
City:		Rent: <input type="checkbox"/>	City:	
Dates:	_____ to _____	Monthly Rent: \$ _____	Phone:	

Previous Address:			Landlord Name:	
Street:		Own: <input type="checkbox"/>	Address:	
City:		Rent: <input type="checkbox"/>	City:	
Dates:	_____ to _____	Monthly Rent: \$ _____	Phone:	

If additional space is required, please use the back of this form.

ALL QUESTIONS MUST BE COMPLETED AND VERIFICATION ATTACHED. Check YES or NO for the following:

YES NO

- Are you a registered sex offender?
- Have you ever been convicted of a crime (*excluding traffic offenses*)? If YES, please explain: _____
- Have your ever been evicted? If YES, when and for what reason: _____
- Do you have any pets? If YES, provide the type and/or breed: _____
- Do require a handicap accessible unit or special accommodations (*i.e. 1st floor, grab bars, etc.*)? _____
- Do you certify this will be your primary place of residence?

THIS PROPERTY MAY ENTITLE YOU TO AN ELDERLY/DISABLED DEDUCTION. IF YOU BELIEVE YOU QUALIFY PLEASE "CHECK" THE BOX:

(Check YES or NO)		INCOME SOURCE	MONTHLY GROSS INCOME
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	EMPLOYMENT: Applicant Name: _____ Employer Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Applicant Name: _____ Employer Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	SELF EMPLOYED: (Must attach last two years of tax returns)	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	UNEMPLOYMENT BENEFITS: State in which benefits are paid: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	WORKERS COMPENSATION BENEFITS: Applicant Name: _____ Company Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	PENSION, RETIREMENT, ANNUITY, INHERITANCE, INSURANCE OR LOTTERY PAYMENTS: Applicant Name: _____ Company Name: _____ Address: _____ Phone: _____ Policy Number: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	VETERAN ADMINISTRATION, GI BILL, NATION GUARD OR MILITARY BENEFITS:	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	SUPPLEMENTAL SECURITY OR SOCIAL SECURITY DISABILITY INCOME: (Attach most recent benefits notice) Applicant Name: _____ Applicant Name: _____	\$ _____ \$ _____

(Check YES or NO)		INCOME SOURCE cont.	MONTHLY GROSS INCOME
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	DEATH BENEFITS: Applicant Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	UNEARNED INCOME (i.e. TRUST FUND etc.): <i>(Attach documentation)</i>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	MAINTENANCE, SPOUSAL OR ALIMONY PAYMENTS: Applicant Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	PUBLIC ASSISTANCE (Ex: TANF, AFDC, W2 etc.): <i>(Do not include food share)</i>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	PERCAP PAYMENTS: Applicant Name: _____ Tribal Agency: _____ Applicant Name: _____ Tribal Agency: _____	\$ _____ \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	CHILD SUPPORT PAYMENTS: <i>(Attach a copy of most current order)</i> Agency: _____ Address: _____ <input type="checkbox"/> I am not receiving payments but have a court order through: Agency: _____ Address: _____ <input type="checkbox"/> I am currently pursuing support through: Agency: _____ Address: _____ <input type="checkbox"/> I am not pursuing payments at this time for the following reason: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	CASH CONTRIBUTIONS OR OTHER SOURCE OF INCOME: Source: _____	\$ _____

(Check YES or NO)		STUDENT STATUS	MONTHLY GROSS INCOME
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	DOES THE HOUSEHOLD CONSIST OF PART-TIME OR FULL-TIME STUDENTS? (1 ST Grade or higher) Name: _____ Name: _____ Name: _____	
<input type="checkbox"/>	<input type="checkbox"/>	EDUCATION GRANTS, SCHOLARSHIPS OR OTHER:	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	DOES ANYONE ANTICIPATE BECOMING A FULL-TIME STUDENT IN THE NEXT 12-MONTHS? Name: _____ Name: _____	

If you answered **YES** to either question above, are you: (Check each box that applies)

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Receiving assistance under Title IV? Receiving assistance through a job training program?
Married and filing joint taxes? Single parent with a dependent child(ren) not dependent to
Previous participant in Foster Care? another individual?

(Check YES or NO)		ASSETS	CASH VALUE BALANCE
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	CHECKING ACCOUNT: Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	SAVINGS ACCOUNT: Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	CD'S MONEY MARKET, IRA'S OR OTHER NON-CHECKING ACCOUNTS: Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	STOCKS, SAVINGS BONDS OR OTHER INVESTMENT ACCOUNTS BOUGHT OR SOLD IN THE PAST 12-MONTHS: <i>(Attach a copy)</i> Institute Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	REAL ESTATE OR MOBILE HOME: <i>(Attach a copy of most recent tax bill)</i>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	LAND CONTRACT: <i>(Attach a copy of contract and amortization schedule)</i>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	PERSONAL PROPERTY HELD FOR INVESTMENT PURPOSE <i>(Includes jewelry, gems, coins, stamp collection, etc.):</i>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	OTHER ASSETS <i>(Ex: Pre-paid debit cards etc.):</i> Have you sold, given away or transferred ownership of assets within the last two years for less than fair market value? Type: _____	\$ _____

(Check YES or NO)		DEDUCTIONS	MONTHLY AMOUNT
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	CHILDCARE FOR CHILD(REN) UNDER AGE 13: <input type="checkbox"/> For work <input type="checkbox"/> For school Provider Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> DENTAL <input type="checkbox"/> OPTICAL EXPENSE FOR PAST 12-MONTHS: <i>(Attach copy of receipts)</i> Provider Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	PHYSICIAN/HOSPITAL CO-PAY FOR PAST 12-MONTHS: <i>(Attach copy of receipts)</i> Provider Name: _____ Address: _____ Phone: _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	STOCKS, BONDS OR OTHER INVESTMENT ACCOUNTS BOUGHT OR SOLD IN THE PAST 12-MONTHS: <i>(Attach a copy)</i> Institute Name: _____ Address: _____ Phone: _____	\$ _____

