

HOUSING AND REDEVELOPMENT COMMISSION of the City of Aberdeen

Phone: 605-226-2321

ADDRESS CORRESPONDENCE TO:

2324 3rd Avenue SE
Aberdeen, SD 57401

TENANT CHANGE REPORT FORM

ALL CHANGES MUST BE REPORTED WITHIN TEN DAYS OF OCCURRENCE.

PLEASE REPORT ALL CHANGES PRIOR TO THE 25TH OF THE MONTH TO ALLOW PROPER TIME TO VERIFY INFORMATION.

USE THIS FORM FOR REPORTING ANY CHANGES.
NO CHANGES WILL BE ACCEPTED UNLESS REPORTED ON THIS FORM
(Supply the appropriate documents for the change(s))

Signatures below constitute consent for Aberdeen Housing Authority to contact any agencies, organizations, offices, or individuals necessary to verify any information needed for my/our participation in the housing assistance programs.

DATE: _____

Head of Household Name

Print Name (Person Completing Form)

Signature

Address

Phone

Please fill out the following section(s), which apply to the change(s) being reported.

A. NEW INCOME ___PERMANENT ___TEMPORARY ___SEASONAL

Name of family member with change: _____

Type of income (ex: wage, child support, SS, SSI, etc) _____

Amount receiving: _____ How often received _____

Date when family member starting receiving new income _____

If the new income is from employment, complete the following:

Employer: _____

Employer Address: _____

Employer Phone: _____ Employment starting date: _____

PLEASE ENCLOSE A SIGNED, DATED STATEMENT FROM EMPLOYER TO VERIFY STARTING DATE AND WAGES.

B. INCREASE OR DECREASE IN CURRENT INCOME:

Name of family member with change: _____

Type of income (ex: wage, child support, SS, SSI, etc) _____

___Increase ___Decrease

New amount receiving: _____ How often received: _____

Date when this increase/decrease started: _____

If this change is due to employment, complete the following:

Employer: _____

Employer Address: _____

Employer Phone: _____

C. TERMINATION OF INCOME:

Name of family member with change: _____

Type of income that terminated (wage, child support, SS, SSI, etc) _____

If termination is due to loss of employment, complete the following:

Employer: _____

Employer Address: _____

Employer Phone: _____ Last date of employment: _____

D. CHANGE OF FAMILY MEMBERS:

Family members who have moved **into** or **out** of the household:

| <u>Legal Name</u> | <u>Relation</u> | <u>Age</u> | <u>Sex</u> | <u>Birthdate</u> | <u>Birthplace</u> |
|-------------------|-----------------|------------|------------|------------------|-------------------|
|-------------------|-----------------|------------|------------|------------------|-------------------|

1. _____ SS# _____

2. _____ SS# _____

3. _____ SS# _____

Date moved In: _____

Date Moved Out: _____

E. CHANGE OF CHILDCARE COSTS:

____ I have the following childcare costs:

Name of childcare provider: _____

Address of childcare provider: _____ Phone: _____

Amount of childcare cost: _____ How often paid: _____

Name of children childcare is provided for: _____

Amount of childcare reimbursement, if any _____

____ I no longer pay childcare costs. Date last paid for childcare _____

F. CHANGE IN MEDICAL EXPENSES:

I have the following changes in medical expenses: _____

I no longer have the following medical expenses: _____

COMMENT SECTION (For office use only):

Employee Initials _____ Date Received _____