Mitch Roth
Mayor

Susan Kunz
Housing Administrator

County of Hawaii
OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT
EXISTING HOUSING DIVISION
1990 Kino'ole Street, Suite 102 • Hilo, Hawai'i 96720
Existing Housing: (808) 959-4642 • Fax (808) 959-9308
Kona: (808) 323-4300 • Fax (808) 323-4301
Email: sec8info@hawaiicounty.gov

App# _____

CHANGE FORM

Changes to your family information must be reported within 30 days and must be submitted in writing. You may submit changes in writing by email, mail, or by drop off at our Kona Office, Hilo Office or Hilo drop box. If you are using this CHANGE FORM all sections must be filled out COMPLETELY. Please use BLACK OR BLUE PEN ONLY to complete this form. If any question do NOT apply, please acknowledge by writing NONE or NOT APPLICABLE. Do not leave any section unanswered.

GENERAL INFORMATION **EMAIL ADDRESS:** _____

Head of Household: _____
Legal Last Name First Name MI

Phone Number: Home: _____ Work: _____ Other: _____

Mailing Address: _____ Apt. No._____

City: _____ State: _____ Zip: _____

PART 1: REQUEST TO ADD FAMILY MEMBERS TO HOUSEHOLD

Are you reporting an ADDITION to your Household* □ *Yes* □ *No

If you answered YES, please complete the following section. If you answered NO, please skip to Part 2.

Birth certificate, social security card, and written permission from your landlord MUST be included with this form.

Enter one of the following codes in the "Relation" box to identify the household relationship of each adult and child listed.

H = Head of Household *K = Co-Head (Not Married)* Y = Youth Under 18 L = Live In Aide
S = Spouse (Married) F = Foster Child/ Adult E = Full Time Student Over 18 A = Other Adult

1. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation	Disabled ☐ Yes ☐ No
Race (check all that apply) ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/ ☐ Asian ☐ Black/African American Other Pacific Islander			Ethnicity (check one box) ☐ Hispanic ☐ Not Hispanic		Social Security Number	
2. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation	Disabled ☐ Yes ☐ No
Race (check all that apply) ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/ ☐ Asian ☐ Black/African American Other Pacific Islander			Ethnicity (check one box) ☐ Hispanic ☐ Not Hispanic		Social Security Number	
3. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation	Disabled ☐ Yes ☐ No
Race (check all that apply) ☐ White ☐ American Indian / Alaska Native ☐ Native Hawaiian/ ☐ Asian ☐ Black/African American Other Pacific Islander			Ethnicity (check one box) ☐ Hispanic ☐ Not Hispanic		Social Security Number	
4. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation	Disabled ☐ Yes ☐ No
Race (check all that apply) ☐ White ☐ American Indian / Alaska Native ☐ Native Hawaiian/ ☐ Asian ☐ Black/African American Other Pacific Islander			Ethnicity (check one box) ☐ Hispanic ☐ Not Hispanic		Social Security Number	

PART 2: REQUEST TO REMOVE FAMILY MEMBERS FROM THE HOUSEHOLD

Are you reporting a REMOVAL of a Household member? □ ***Yes*** □ ***No***

If you answered YES, please complete the following section. If you answered NO, please skip to Part 3.

Enter one of the following codes in the "Relation" box to identify the household relationship of each adult and child listed.

H = Head of Household *K = Co-Head (Not Married)* Y = Youth Under 18 L = Live In Aide
S = Spouse (Married) F = Foster Child/ Adult E = Full Time Student Over 18 A = Other Adult

1. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Relation	Social Security Number
2. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Relation	Social Security Number
3. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Relation	Social Security Number
4. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Relation	Social Security Number
5. Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Relation	Social Security Number

PART 3: ASSETS CHANGES

Are you reporting any changes to your assets? □ ***Yes*** □ ***No***

If you answered YES, please complete the following section. If you answered NO, please skip to Part 4.

Please list below **NEW AND CHANGES TO EXISTING** stocks, bonds, annuities, savings bonds, credit union shares, trust accounts, retirement contributions, pension contributions, IRA's, certificates or deposit or other assets for **EVERYONE** in your household. Also include assets that are held jointly with another and include the joint holder's name.

FAMILY MEMBER	NAME OF FINANCIAL INSTITUTION	TYPE OF ASSETS	TYPE OF ACCOUNT	ACCOUNT NUMBER	ESTIMATED CURRENT BALANCE

PART 4: INCOME CHANGES

Are you reporting any changes to your income? □ ***Yes*** □ ***No***

If you answered YES, please complete the following section. If you answered NO, please skip to Part 5.

Note: **You MUST include ALL NEW AND CHANGES TO EXISTING household income.** **You MUST provide complete names and addresses of income source(s). IF YOU HAVE A CHECK STUB(s), PLEASE ATTACH.**
Please list gross payments (before taxes) made to each family member, including children and temporarily absent household members, for wages, worker's compensation, social security, SSI, disability, welfare assistance, unemployment benefits, retirement payments, child support, reimbursements, military pay, periodic gifts, barter income, and business or professional income. Include payments made to family members age 18 or older on behalf of other family members under age 18.

FAMILY MEMBER	TYPE OF INCOME (i.e. Employment, SSI, …)	SOURCE OF INCOME (i.e. ABC Company)	ESTIMATED MONTHLY AMOUNT

PART 5: CHILD CARE / MEDICAL EXPENSES

Do you wish to report a new or change to existing out-of-pocket Child Care Expenses? □ ***Yes*** □ ***No***

Do you wish to report a new or change to existing out-of-pocket Medical Expenses? □ ***Yes*** □ ***No***

If you answered YES, please complete the following section. If you answered NO, please skip to Part 6.

Name and Address of Care Provider for Verification:

Name: _____ Address: _____

City: _____ State: _____ Zip_____ Telephone: _____

Date Child Care Began: _____ Average Hours Per Week: _____

Amount you Pay ($): _____ (check one) ☐per hour ☐per week ☐per bi-weekly ☐per month

Amount Reimbursed by an individual/ organization: $ _____ Name of Organization: _____

Complete only if the Head of Household, Spouse, or Co-Head is disabled or age 62 or older.

If you wish to claim an allowance for out-of-pocket (unreimbursed) medical insurance premiums, medical, dental or optical expenses, or prescription or over-the-counter drug expenses, please provide the first name of any family member claiming each expense and the name and address of the provider of the service or product.

YES	NO			
☐	☐	Do you have Medicare (Social Security)?	If YES, Monthly Premium Amount:	$ _____
☐	☐	Do you have Medicaid (Welfare)?		
☐	☐	Do you have other Medical Insurance?	If YES, Monthly Premium Amount:	$ _____
☐	☐	Are you paying on any medical bills?	If YES, Monthly Premium Amount:	$ _____
			Balance Amount:	$ _____

Family Member First Name : _____
Expense Claimed: $ _____
Provider: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Family Member First Name : _____
Expense Claimed: $ _____
Provider: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

PART 6:
If you give incomplete information, do not have all adult members (over age 18) sign this form, or fail to provide complete verification, one of the following may take place:

1) If you are reporting an upward change in your income your rent change may be delayed and /or **YOU MAY OWE A RETROACTIVE RENT AMOUNT.**

2) If you are reporting a downward change in your income, your **RENT MAY NOT BE REDUCED UNTIL THE FOLLOWING MONTH.**

APPLICANT'S CERTIFICATION

GIVING TRUE AND COMPLETE INFORMATION
*I/We understand that the above information is being collected to determine my/our eligibility for Section 8 assistance. Information given will be verified and may be released by and to appropriate federal, state and local agencies. I/We hereby certify that the statements made in this application are **true AND complete** to the best of my/our knowledge and belief. I/We also understand that misrepresentation of information or failure to disclose information may disqualify me/us from consideration for continued eligibility and may be grounds for termination of assistance.*

WARNING:
Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make false documents or misrepresentation to any department or agency of the United States as to any matter within its jurisdiction.

NOTICE:
Any attempt to obtain Public Housing, any rent subsidy or rent reduction by false information, impersonation, failure to disclose or other fraud, and any act of assistance to such attempt is a crime under Hawaii Revised Statutes, Sec. 710-1063.

If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please contact the Office of Housing and Community Development – Existing Housing Division at (808) 959-4642 (HILO) and (808) 323-4300.

In accordance with federal requirements, the Office of Housing and Community Development is required to collect information on age, sex, race and ethnicity. The information you provide will not be used to determine your eligibility for the program.

If you are submitting this form electronically, typing your name below is equivalent to signing this document.

_____ _____
(Print Name & Signature of Head of Household) Date

_____ _____
(Print Name & Signature of Other Household Adult Member) Date

_____ _____
(Print Name & Signature of Other Household Adult Member) Date

_____ _____
(Print Name & Signature of Other Household Adult Member) Date

INTERNAL OFFICE USE ONLY:
I do hereby certify that I have reviewed all answers and certifications with applicant: _____ OHCD Representative.