resident questionnaire

capital magnet fund

The following information is requested in order to comply with federal regulations associated with the Capital Magnet Fund administered by US Treasury, which require that properties collect certain information necessary to determine annual adjusted income as calculated under HUD guidelines.

Although the property owner/management agent is required to request this information from you, you may choose not to furnish it. Your eligibility and rent will not be determined based on this information, or on whether you choose to furnish it. If your household does not wish to furnish this information, please check the box below. All adults must sign and date on page 2.

Head of Household Name	Unit Number

☐ Resident(s)/Applicant(s): I/we do not wish to furnish information regarding the expenses set forth below. Please ensure all adults sign and date on page 2.

child care expenses		amount paid per month
Do you pay child care expenses for a child (or children) under age 13 because you: (check one box only) ☐ work? ☐ are actively looking for work? ☐ attend school?	☐ Yes ☐ No	$
If yes, enter the provider name(s) and address(es):		
Is any part of the child care expense paid by another person or agency?	☐ Yes ☐ No	$
If yes, enter the name and address:		

disability assistance expenses		amount paid per month
Do you pay for attendant care services or any equipment for a disabled household member necessary to enable that person or someone else in the household to work?	☐ Yes ☐ No	$
If yes, enter the provider's name and address:		
Is any part of the care attendant expense paid by another person or agency?	☐ Yes ☐ No	$
If yes, enter the name and address:		

medical expenses (complete only if the head of household, spouse, or adult co-head is at least 62 years old or disabled)

Enter unreimbursed medical expenses for all household members on the next page.

hh mbr	full name	types of medical expenses	amount
			$
			$
			$

		amount paid per month
Do you have Medicare?	☐ Yes ☐ No	$
Do you have Medicare Part D?	☐ Yes ☐ No	$
Do you have any other kind of medical insurance that you pay a premium for?	☐ Yes ☐ No	$
If yes, enter the company name and address:		
Do you pay for prescription medications?	☐ Yes ☐ No	$
If yes, enter the pharmacy name and address:		
Do you have any non-prescription (over the counter) medication that your doctor has asked you to use regularly? (such as aspirin, insulin, etc.)	☐ Yes ☐ No	$
If yes, list the medication(s):		
Do you expect to have any medical or dental expense in the next 12 months?	☐ Yes ☐ No	$
If yes, enter the type of expense:		

If forms are completed electronically, one of the following boxes must be checked:

☐ **This form was completed electronically by the resident.**

☐ **Management or someone outside of household assisted with completing the form electronically (Authorization to Assist is attached).**

signatures

Warning: Section 1001 of Title 18 of the US Code makes it a criminal offense to willfully falsify a material fact or make a false statement in any matter within the jurisdiction of a federal agency.

I certify that the information supplied in this form is true and correct to the best of my knowledge.

Applicant/Resident Signature Date

Applicant/Resident Signature Date

Applicant/Resident Signature Date