U.S. Department of Housing and Urban Development

Document Package for Applicant's/Tenant's Consent to the Release Of Information

This Package contains the following documents:

1. **HUD-9887/A Fact Sheet describing the necessary verifications**
2. **Form HUD-9887 (to be signed by the Applicant or Tenant)**
3. **Form HUD-9887-A (to be signed by the Applicant or Tenant and Housing Owner)**
4. **Relevant Verifications (to be signed by the Applicant or Tenant)**

Each household must receive a copy of the 9887/A Fact Sheet, form HUD-9887, and form HUD-9887-A.

HUD-9887/A Fact Sheet

Verification of Information Provided by Applicants and Tenants of Assisted Housing

What Verification Involves

To receive housing assistance, applicants and tenants who are at least 18 years of age and each family head, spouse, or co-head regardless of age must provide the owner or management agent (O/A) or public housing agency (PHA) with certain information specified by the U.S. Department of Housing and Urban Development (HUD).

To make sure that the assistance is used properly, Federal laws require that the information you provide be verified. This information is verified in two ways:

1. HUD, O/As, and PHAs may verify the information you provide by checking with the records kept by certain public agencies (e.g., Social Security Administration (SSA), State agency that keeps wage and unemployment compensation claim information, and the Department of Health and Human Services' (HHS) National Directory of New Hires (NDNH) database that stores wage, new hires, and unemployment compensation). HUD (only) may verify information covered in your tax returns from the U.S. Internal Revenue Service (IRS). You give your consent to the release of this information by signing form HUD-9887. Only HUD, O/As, and PHAs can receive information authorized by this form.

2. The O/A must verify the information that is used to determine your eligibility and the amount of rent you pay. You give your consent to the release of this information by signing the form HUD-9887, the form HUD-9887-A, and the individual verification and consent forms that apply to you. Federal laws limit the kinds of information the O/A can receive about you. The amount of income you receive helps to determine the amount of rent you will pay. The O/A will verify all of the sources of income that you report. There are certain allowances that reduce the income used in determining tenant rents.

   Example: Mrs. Anderson is 62 years old. Her age qualifies her for a medical allowance. Her annual income will be adjusted because of this allowance. Because Mrs. Anderson's medical expenses will help determine the amount of rent she pays, the O/A is required to verify any medical expenses that she reports.

   Example: Mr. Harris does not qualify for the medical allowance because he is not at least 62 years of age and he is not handicapped or disabled. Because he is not eligible for the medical allowance, the amount of his medical expenses does not change the amount of rent he pays. Therefore, the O/A cannot ask Mr. Harris anything about his medical expenses and cannot verify with a third party about any medical expenses he has.

Customer Protections

Information received by HUD is protected by the Federal Privacy Act. Information received by the O/A or the PHA is subject to State privacy laws. Employees of HUD, the O/A, and the PHA are subject to penalties for using these consent forms improperly. You do not have to sign the form HUD-9887, the form HUD-9887-A, or the individual verification consent forms when they are given to you at your certification or recertification interview. You may take them home with you to read or to discuss with a third party of your choice. The O/A will give you another date when you can return to sign these forms.

If you cannot read and/or sign a consent form due to a disability, the O/A shall make a reasonable accommodation in accordance with Section 504 of the Rehabilitation Act of 1973. Such accommodations may include: home visits when the applicant's or tenant's disability prevents him/her from coming to the office to complete the forms; the applicant or tenant authorizing another person to sign on his/her behalf; and for persons with visual impairments, accommodations may include providing the forms in large script or braille or providing readers.

If an adult member of your household, due to extenuating circumstances, is unable to sign the form HUD-9887 or the individual verification forms on time, the O/A may document the file as to the reason for the delay and the specific plans to obtain the proper signature as soon as possible.

The O/A must tell you, or a third party which you choose, of the findings made as a result of the O/A verifications authorized by your consent. The O/A must give you the opportunity to contest such findings in accordance with HUD Handbook 4350.3 Rev. 1. However, for information received under the form HUD-9887 or form HUD-9887-A, HUD, the O/A, or the PHA, may inform you of these findings.

O/As must keep tenant files in a location that ensures confidentiality. Any employee of the O/A who fails to keep tenant information confidential is subject to the enforcement provisions of the State Privacy Act and is subject to enforcement actions by HUD. Also, any applicant or tenant affected by negligent disclosure or improper use of information may bring civil action for damages, and seek other relief, as may be appropriate, against the employee.

HUD-9887/A requires the O/A to give each household a copy of the Fact Sheet, and forms HUD-9887, HUD-9887-A along with appropriate individual consent forms. The package you will receive will include the following documents:

1. **HUD-9887/A Fact Sheet**: Describes the requirement to verify information provided by individuals who apply for housing assistance. This fact sheet also describes consumer protections under the verification process.
2. **Form HUD-9887:** Allows the release of information between government agencies.
3. **Form HUD-9887-A:** Describes the requirement of third party verification along with consumer protections.
4. **Individual verification consents:** Used to verify the relevant information provided by applicants/tenants to determine their eligibility and level of benefits.

Consequences for Not Signing the Consent Forms

If you fail to sign the form HUD-9887, the form HUD-9887-A, or the individual verification forms, this may result in your assistance being denied (for applicants) or your assistance being terminated (for tenants). See further explanation on the forms HUD-9887 and 9887-A.

If you are an applicant and are denied assistance for this reason, the O/A must notify you of the reason for your rejection and give you an opportunity to appeal the decision.

If you are a tenant and your assistance is terminated for this reason, the O/A must follow the procedures set out in the Lease. This includes the opportunity for you to meet with the O/A.

Programs Covered by this Fact Sheet

Rental Assistance Program (RAP)

Rent Supplement

Section 8 Housing Assistance Payments Programs (administered by the Office of Housing)

Section 202

Sections 202 and 811 PRAC

Section 202/162 PAC

Section 221(d)(3) Below Market Interest Rate

Section 236

HOPE 2 Home Ownership of Multifamily Units

O/As must give a copy of this HUD Fact Sheet to each household. See the Instructions on form HUD-9887-A.

Notice and Consent for the Release of Information

to the U.S. Department of Housing and Urban Development (HUD) and to an Owner and Management Agent (O/A), and to a Public Housing Agency (PHA)

U.S. Department of Housing and Urban Development
Office of Housing
Federal Housing Commissioner

HUD Office requesting release of information (Owner should provide the full address of the HUD Field Office, Attention: Director, Multifamily Division.):	O/A requesting release of information (Owner should provide the full name and address of the Owner.):	PHA requesting release of information (Owner should provide the full name and address of the PHA and the title of the director or administrator. If there is no PHA Owner or PHA contract administrator for this project, mark an X through this entire box.):

Notice To Tenant: Do not sign this form if the space above for organizations requesting release of information is left blank. You do not have to sign this form when it is given to you. You may take the form home with you to read or discuss with a third party of your choice and return to sign the consent on a date you have worked out with the housing owner/manager.

Authority: Section 217 of the Consolidated Appropriations Act of 2004 (Pub L. 108-199). This law is found at 42 U.S.C.653(J). This law authorizes HHS to disclose to the Department of Housing and Urban Development (HUD) information in the NDNH portion of the "Location and Collection System of Records" for the purposes of verifying employment and income of individuals participating in specified programs and, after removal of personal identifiers, to conduct analyses of the employment and income reporting of these individuals. Information may be disclosed by the Secretary of HUD to a private owner, a management agent, and a contract administrator in the administration of rental housing assistance.

Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by section 903 of the Housing and Community Development Act of 1992 and section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.This law requires you to sign a consent form authorizing: (1) HUD and the PHA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; and (2) HUD, O/A, and the PHA responsible for determining eligibility to verity salary and wage information pertinent to the applicant's or participant's eligibility or level of benefits; (3) HUD to request certain tax return information from the U.S. Social Security Administration (SSA) and the U.S. Internal Revenue Service (IRS).

Purpose: In signing this consent form, you are authorizing HUD, the above-named O/A, and the PHA to request income information from the government agencies listed on the form. HUD, the O/A, and the PHA need this information to verify your household's income to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD, the O/A, and the PHA may participate in computer matching programs with these sources to verify your eligibility and level of benefits. This form also authorizes HUD, the O/A, and the PHA to seek wage, new hire (W-4), and unemployment claim information from current or former employers to verify information obtained through computer matching.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. The O/A and the PHA is also required to protect the income information it obtains in accordance with any applicable State privacy law. After receiving the information covered by this notice of consent, HUD, the O/A, and the PHA may inform you that your eligibility for, or level of, assistance is uncertain and needs to be verified and nothing else.

HUD, O/A, and PHA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form.

Who Must Sign the Consent Form: Each member of your household who is at least 18 years of age and each family head, spouse or co-head, regardless of age, must sign the consent form at the initial certification and at each recertification. Additional signatures must be obtained from new adult members when they join the household or when members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

Rental Assistance Program (RAP)

Rent Supplement

Section 8 Housing Assistance Payments Programs (administered by the Office of Housing)

Section 202; Sections 202 and 811 PRAC; Section 202/162 PAC Section

221(d)(3) Below Market Interest Rate

Section 236

HOPE 2 Homeownership of Multifamily Units

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of assistance or termination of assisted housing benefits. If an applicant is denied assistance for this reason, the owner must follow the notification procedures in Handbook 4350.3 Rev. 1. If a tenant is denied assistance for this reason, the owner or managing agent must follow the procedures set out in the lease.

Consent: I consent to allow HUD, the O/A, or the PHA to request and obtain income information from the federal and state agencies listed on the back of this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs.

Signatures:

Additional Signatures, if needed:

Head of Household	Date	Other Family Members 18 and Over	Date
Spouse	Date	Other Family Members 18 and Over	Date
Other Family Members 18 and Over	Date	Other Family Members 18 and Over	Date
Other Family Members 18 and Over	Date	Other Family Members 18 and Over	Date

Agencies To Provide Information

State Wage Information Collection Agencies. (HUD and PHA). This consent is limited to wages and unemployment compensation you have received during period(s) within the last 5 years when you have received assisted housing benefits.

U.S. Social Security Administration (HUD only). This consent is limited to the wage and self employment information from your current form W-2.

National Directory of New Hires contained in the Department of Health and Human Services' system of records. This consent is limited to wages and unemployment compensation you have received during period(s) within the last 5 years when you have received assisted housing benefits.

U.S. Internal Revenue Service (HUD only). This consent is limited to information covered in your current tax return.

This consent is limited to the following information that may appear on your current tax return:

1099-S Statement for Recipients of Proceeds from Real Estate Transactions

1099-B Statement for Recipients of Proceeds from Real Estate Brokers and Barters Exchange Transactions

1099-A Information Return for Acquisition or Abandonment of Secured Property

1099-G Statement for Recipients of Certain Government Payments

1099-DIV Statement for Recipients of Dividends and Distributions

1099 INT Statement for Recipients of Interest Income

1099-MISC Statement for Recipients of Miscellaneous Income

1099-OID Statement for Recipients of Original Issue Discount

1099-PATR Statement for Recipients of Taxable Distributions Received from Cooperatives

1099-R Statement for Recipients of Retirement Plans W2-G

Statement of Gambling Winnings

1065-K1 Partners Share of Income, Credits, Deductions, etc.

1041-K1 Beneficiary's Share of Income, Credits, Deductions, etc.

1120S-K1 Shareholder's Share of Undistributed Taxable Income, Credits, Deductions, etc.

I understand that income information obtained from these sources will be used to verify information that I provide in determining initial or continued eligibility for assisted housing programs and the level of benefits.

No action can be taken to terminate, deny, suspend, or reduce the assistance your household receives based on information obtained about you under this consent until the HUD Office, Office of Inspector General (OIG) or the PHA (whichever is applicable) and the O/A have independently verified: 1) the amount of the income, wages, or unemployment compensation involved, 2) whether you actually have (or had) access to such income, wages, or benefits for your own use, and 3) the period or periods when, or with respect to which you actually received such income, wages, or benefits. A photocopy of the signed consent may be used to request a third party to verify any information received under this consent (e.g., employer).

HUD, the O/A, or the PHA shall inform you, or a third party which you designate, of the findings made on the basis of information verified under this consent and shall give you an opportunity to contest such findings in accordance with Handbook 4350.3 Rev. 1.

If a member of the household who is required to sign the consent form is unable to sign the form on time due to extenuating circumstances, the O/A may document the file as to the reason for the delay and the specific plans to obtain the proper signature as soon as possible.

This consent form expires 15 months after signed.

Privacy Act Statement. The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937, as amended (42 U.S.C. 1437 et. seq.); the Housing and Urban-Rural Recovery Act of 1983 (P.L. 98-181); the Housing and Community Development Technical Amendments of 1984 (P.L. 98-479); and by the Housing and Community Development Act of 1987 (42 U.S.C. 3543). The information is being collected by HUD to determine an applicant's eligibility, the recommended unit size, and the amount the tenant(s) must pay toward rent and utilities. HUD uses this information to assist in managing certain HUD properties, to protect the Government's financial interest, and to verify the accuracy of the information furnished. HUD, the owner or management agent (O/A), or a public housing agency (PHA) may conduct a computer match to verify the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. You must provide all of the information requested. Failure to provide any information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:
HUD, the O/A, and any PHA (or any employee of HUD, the O/A, or the PHA) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9887 is restricted to the purposes cited on the form HUD 9887. Any person who knowingly or willfully requests, obtains, or discloses any information under false pretenses concerning an applicant or tenant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or tenant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the Owner or the PHA responsible for the unauthorized disclosure or improper use.

Applicant's/Tenant's Consent to the Release of Information

Verification by Owners of Information
Supplied by Individuals Who Apply for Housing Assistance

U.S. Department of Housing and Urban Development
Office of Housing
Federal Housing Commissioner

Instructions to Owners

1. Give the documents listed below to the applicants/tenants to sign. Staple or clip them together in one package in the order listed.
   a. The HUD-9887/A Fact Sheet.
   b. Form HUD-9887.
   c. Form HUD-9887-A.
   d . Relevant verifications (HUD Handbook 4350.3 Rev. 1).
2. Verbally inform applicants and tenants that
   a. They may take these forms home with them to read or to discuss with a third party of their choice and to return to sign them on a date they have worked out with you, and
   b. If they have a disability that prevents them from reading and/ or signing any consent, that you, the Owner, are required to provide reasonable accommodations.
3. Owners are required to give each household a copy of the HUD9887/A Fact Sheet, form HUD-9887, and form HUD-9887-A after obtaining the required applicants/tenants signature(s). Also, owners must give the applicants/tenants a copy of the signed individual verification forms upon their request.

Instructions to Applicants and Tenants

This Form HUD-9887-A contains customer information and protections concerning the HUD-required verifications that Owners must perform.

1. Read this material which explains:
   • HUD's requirements concerning the release of information, and
   • Other customer protections.
2. Sign on the last page that:
   • you have read this form, or
   • the Owner or a third party of your choice has explained it to you, and
   • you consent to the release of information for the purposes and uses described.

Authority for Requiring Applicant's/Tenant's Consent to the Release of Information

Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by section 903 of the Housing and Community Development Act of 1992. This law is found at 42 U.S.C. 3544.

In part, this law requires you to sign a consent form authorizing the Owner to request current or previous employers to verify salary and wage information pertinent to your eligibility or level of benefits.

In addition, HUD regulations (24 CFR 5.659, Family Information and Verification) require as a condition of receiving housing assistance that you must sign a HUD-approved release and consent authorizing any depository or private source of income to furnish such information that is necessary in determining your eligibility or level of benefits. This includes information that you have provided which will affect the amount of rent you pay. The information includes income and assets, such as salary, welfare benefits, and interest earned on savings accounts. They also include certain adjustments to your income, such as the allowances for dependents and for households whose heads or spouses are elderly handicapped, or disabled; and allowances for child care expenses, medical expenses, and handicap assistance expenses.

Purpose of Requiring Consent to the Release of Information

In signing this consent form, you are authorizing the Owner of the housing project to which you are applying for assistance to request information from a third party about you. HUD requires the housing owner to verify all of the information you provide that affects your eligibility and level of benefits to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct levels. Upon the request of the HUD office or the PHA (as Contract Administrator), the housing Owner may provide HUD or the PHA with the information you have submitted and the information the Owner receives under this consent.

Uses of Information to be Obtained

The individual listed on the verification form may request and receive the information requested by the verification, subject to the limitations of this form. HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. The Owner and the PHA are also required to protect the income information they obtain in accordance with any applicable state privacy law. Should the Owner receive information from a third party that is inconsistent with the information you have provided, the Owner is required to notify you in writing identifying the information believed to be incorrect. If this should occur, you will have the opportunity to meet with the Owner to discuss any discrepancies.

Who Must Sign the Consent Form

Each member of your household who is at least 18 years of age, and each family head, spouse or co-head, regardless of age must sign the relevant consent forms at the initial certification, at each recertification and at each interim certification, if applicable. In addition, when new adult members join the household and when members of the household become 18 years of age they must also sign the relevant consent forms.

Persons who apply for or receive assistance under the following programs must sign the relevant consent forms:

Rental Assistance Program (RAP)
Rent Supplement
Section 8 Housing Assistance Payments Programs (administered by the Office of Housing)
Section 202
Sections 202 and 811 PRAC
Section 202/162 PAC
Section 221(d)(3) Below Market Interest Rate
Section 236
HOPE 2 Home Ownership of Multifamily Units

Failure to Sign the Consent Form

Failure to sign any required consent form may result in the denial of assistance or termination of assisted housing benefits. If an applicant is denied assistance for this reason, the O/A must follow the notification procedures in Handbook 4350.3 Rev. 1. If a tenant is denied assistance for this reason, the O/A must follow the procedures set out in the lease.

Conditions

No action can be taken to terminate, deny, suspend or reduce the assistance your household receives based on information obtained about you under this consent until the O/A has independently 1) verified the information you have provided with respect to your eligibility and level of benefits and 2) with respect to income (including both earned and unearned income), the O/A has verified whether you actually have (or had) access to such income for your own use, and verified the period or periods when, or with respect to which you actually received such income, wages, or benefits.

A photocopy of the signed consent may be used to request the information authorized by your signature on the individual consent forms. This would occur if the O/A does not have another individual verification consent with an original signature and the O/A is required to send out another request for verification (for example, the third party fails to respond). If this happens, the O/A may attach a photocopy of this consent to a photocopy of the individual verification form that you sign. To avoid the use of photocopies, the O/A and the individual may agree to sign more than one consent for each type of verification that is needed. The O/A shall inform you, or a third party which you designate, of the findings made on the basis of information verified under this consent and shall give you an opportunity to contest such findings in accordance with Handbook 4350.3 Rev. 1.

The O/A must provide you with information obtained under this consent in accordance with State privacy laws.

If a member of the household who is required to sign the consent forms is unable to sign the required forms on time, due to extenuating circumstances, the O/A may document the file as to the reason for the delay and the specific plans to obtain the proper signature as soon as possible.

Individual consents to the release of information expire 15 months after they are signed. The O/A may use these individual consent forms during the 120 days preceding the certification period. The O/A may also use these forms during the certification period, but only in cases where the O/A receives information indicating that the information you have provided may be incorrect. Other uses are prohibited.

The O/A may not make inquiries into information that is older than 12 months unless he/she has received inconsistent information and has reason to believe that the information that you have supplied is incorrect. If this occurs, the O/A may obtain information within the last 5 years when you have received assistance.

I have read and understand this information on the purposes and uses of information that is verified and consent to the release of information for these purposes and uses.

_____

Name of Applicant or Tenant (Print)

_____

Signature of Applicant or Tenant & Date

I have read and understand the purpose of this consent and its uses and I understand that misuse of this consent can lead to personal penalties to me.

_____

Name of Project Owner or his/her representative

_____

Title

_____

Signature & Date

cc:Applicant/Tenant

Owner file

Penalties for Misusing this Consent:

HUD, the O/A, and any PHA (or any employee of HUD, the O/A, or the PHA) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9887-A is restricted to the purposes cited on the form HUD 9887-A. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or tenant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or tenant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the O/A or the PHA responsible for the unauthorized disclosure or improper use.

Family Service Association of Bucks County
Housing Subsidy/HUD PRAC 811
ADL Assessment Form

Client's Name: _____ **DOB:** _____

Instructions: Write in the appropriate value number on the score lines provided to the right.

1. TOILET — Value #
   - 4 Cares for self at toilet completely, no incontinence
   - 3 Needs to be reminded, or needs help in cleaning self, or has rare (weekly at most) accidents
   - 2 Soiling or wetting while asleep, more than once a week
   - 1 Soiling or wetting while awake, more than once awake
   - 0 No control over bowels or bladder

   _____

2. FEEDING
   - 4 Eats without assistance
   - 3 Eats with minor assistance at meal times, with help preparing food or w/help cleaning up
   - 2 Feeds self with moderate assistance and is untidy
   - 1 Requires extensive assistance for all meals
   - 0 Does not feed self at all and resists efforts of others to feed him/her

   _____

3. DRESSING
   - 4 Dresses, undresses and selects clothes from own wardrobe
   - 3 Dresses and undresses self, with minor assistance
   - 2 Needs moderate assistance in dressing or selecting of clothes
   - 1 Needs major assistance in dressing but cooperates with efforts of another to help
   - 0 Completely unable to dress self and resists efforts of another to help

   _____

4. GROOMING (neatness, hair, nails, hands, face, clothing)
   - 4 Always neatly dressed and well-groomed, without assistance
   - 3 Grooms self adequately, with occasional minor assistance, e.g. in shaving
   - 2 Needs moderate and regular assistance or supervision in grooming
   - 1 Needs major assistance in dressing but cooperates with efforts of another to help
   - 0 Actively negates all efforts to others to maintain grooming

   _____

5. PHYSICAL AMBULATION
   - 4 Goes about grounds or city
   - 3 Ambulates within residence or about one block distance
   - 2 Ambulates with assistance of (check one): _____ another person, _____ railing, _____ cane _____ walker, _____ wheelchair: ___ gets in/out without help ____ needs help getting in/out
   - 1 Sits unsupported in chair or wheelchair, but cannot propel self without help
   - 0 Bedridden more than half the time

   _____

6. BATHING
   - 4 Bathes self (tub, shower, sponge bath) without help
   - 3 Bathes self, with help of getting in and out of tub
   - 2 Washes face and hands only, but cannot bath rest of body
   - 1 Does not wash self but is cooperative with those who bathe him/her
   - 0 Does not try to wash self, and resists efforts to keep clean

   _____

7. RESPNSIBILITY FOR OWN MEDICATION
   - 2 Is responsible for taking medications in correct dosages at correct time
   - 1 Takes responsibility if medication is prepared in advance in separate dosages
   - 0 Does not take medication without being distributed or refuses to take medications

   _____

_____ _____

Doctor's signature Date Assessed

BUCKS VILLA Inc.
c/o
Family Service Association of Bucks County
4 Cornerstone Drive
Langhorne, PA 19047
Ph 215-757-6916 Fax 215-757-7628
TTY/TDD 215-750-0727
www.bucksvilla.org

General Release Form.

D&A, MH, or HIV-related Information cannot be used/disclosed in reliance on this form unless specified explicitly as such under Item 2. D&A and HIV- related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I, _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA), to use and/or disclose my protected information only as described below:

1. This Authorization's **purpose** is as follows: Consent for FSA to request employment verification from the employer listed below.

2. This Authorization **covers** the following information about me: Name, SSN, DOB, date first employed, gross pay rate, overtime pay rate, expected average hours worked per week, other compensation, total anticipated base pay for the next 12 calendar months and total anticipated overtime earnings for the next 12 calendar months.

3. This Authorization **permits** FSA to release the covered information which it has in its possession. FSA may release this information to the following person(s) or entity(ies):
   Full Proper Name: _____ **Phone #:**_____
   Full Mailing Address: _____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.

5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

6. In the absence of revocation, this Authorization **becomes effective** on *(Specify Date.)*_____ and **will expire** on (*Specify Date or Event)*_____.

7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

8. I understand that FSA may not require that I sign this Authorization in order to obtain treatment.

PENALTIES FOR MISUSING THIS CONSENT:
Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA, and any owner (or any employee of HUD, the PHA, or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a is demeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA, or the owner responsible for the unauthorized disclosure or improper use.

I have read this Authorization, or had it explained to me, and I understand its contents.
FSA has given me a copy of this Authorization. Copy: □ Accepted □ Declined

Client's Signature: _____ **Witness' Signature:** _____

Date in Client's Handwriting _____ **Date in Witness' Handwriting:** _____

BUCKS VILLA Inc.
c/o
Family Service Association of Bucks County
4 Cornerstone Drive
Langhorne, PA 19047
Ph 215-757-6916 Fax 215-757-7628
TTY/TDD 215-750-0727
www.bucksvilla.org

General Release Form.

D&A, MH, or HIV-related Information cannot be used/disclosed in reliance on this form unless specified explicitly as such under Item 2. D&A and HIV- related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I, _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA) to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: To communicate information between the Housing Specialist and the resident's medical case manager.

2. This Authorization **covers** the following information about me: Demographics (including SSN); income; disability status; Behavioral Health/drug/alcohol history (including diagnosis, current/past treatment and clean time); HIV status; presence in Medical Case Management; relevant Service Care Plan goals; progress towards meeting relevant Service Care Plan goals and current health status.

3. This Authorization **permits** FSA to release the covered information which it has in its possession. FSA may release this information to the following person(s) or entity(ies):
   Case Manager's Full and Proper Name/#:_____
   Full Mailing Address: _____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.

5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

6. In the absence of revocation, this Authorization **becomes effective** on *(Specify Date.)*_____ and **will expire** on (*Specify Date or Event)*_____.

7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

8. I understand that FSA may not require that I sign this Authorization in order to obtain treatment.

PENALTIES FOR MISUSING THIS CONSENT:
Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA, and any owner (or any employee of HUD, the PHA, or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a is demeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA, or the owner responsible for the unauthorized disclosure or improper use.

I have read this Authorization, or had it explained to me, and I understand its contents.
FSA has given me a copy of this Authorization. Copy: □ Accepted □ Declined

Client's Signature: _____ **Witness' Signature:** _____

Date in Client's Handwriting _____ **Date in Witness' Handwriting:** _____

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I,___ _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA) to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: Consent for FSA to share income and asset information in order to verify income with HUD verification systems.

2. This Authorization **covers** the following information about me: Name, Address, SSN, DOB, income and assets which may be shared via electronic submission.

3. This Authorization **permits** FSA to release the covered information which it has in its possession. FSA may release this information to the following person(s) or entity(ies):
   Full Proper Name: ___ Paulhus and Associates, Inc._____
   Full Mailing Address: 8 Keystone Drive, Lebanon, PA 17042_____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.

5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

6. In the absence of revocation, this Authorization **becomes effective** on *(Specify Date.)*_____ and **will expire** on (*Specify Date or Event)*_____.

7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

8. I understand that FSA may not require that I sign this Authorization in order to obtain treatment.

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I have read this Authorization, or had it explained to me, and I understand its contents.
FSA has given me a copy of this Authorization. Copy: □ Accepted □ Declined

Client's Signature: _____ **Witness' Signature:** _____

Date in Client's Handwriting _____ **Date in Witness' Handwriting:** _____

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I,___ _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA) to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: To permit access to the applicant's criminal record history.

2. This Authorization **covers** the following information about me: Name, Address, Social Security Number, DOB,

   States lived in during life time

3. This Authorization **permits** FSA to release the covered information which it has in its possession. FSA may release this information to the following person(s) or entity(ies):
   Full Proper Name: Employee Screening Services, Inc. T:215-675-6835 F: 215-675-7451
   Full Mailing Address: 755 York Rd. Suite 102 Warminster, PA 18974

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.

5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

6. In the absence of revocation, this Authorization **becomes effective** on *(Specify Date.)*_____ and **will expire** on (*Specify Date or Event)*_____.

7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

8. I understand that FSA may not require that I sign this Authorization in order to obtain treatment.

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I have read this Authorization, or had it explained to me, and I understand its contents.
FSA has given me a copy of this Authorization. Copy: □ Accepted □ Declined

Client's Signature: _____ **Witness' Signature:** _____

Date in Client's Handwriting _____ **Date in Witness' Handwriting:** _____

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I,___ _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA) to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: To permit access to the applicant's national sex offender registry as a part of meeting federal guidelines in the pre-admission process to Buck Villa._

2. This Authorization **covers** the following information about me: Name, Address, Social Security Number, DOB

3. This Authorization **permits** FSA to release the covered information which it has in its possession. FSA may release this information to the following person(s) or entity(ies):
   Full Proper Name: ___Dru Sjodin National Sex Offender database _____
   Full Mailing Address: http://www.nsopw.gov _____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.

5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

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7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

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I have read this Authorization, or had it explained to me, and I understand its contents.
FSA has given me a copy of this Authorization. Copy: □ Accepted □ Declined

Client's Signature: _____ **Witness' Signature:** _____

Date in Client's Handwriting _____ **Date in Witness' Handwriting:** _____

ASSET VERIFICATION FORM

Checking, Savings, Certificate of Deposit, and Money Market Accounts

Name of Financial Organization: _____

PLEASE RETURN FORM TO: Nathan Townsend
Address: __Family Service Association 4 Cornerstone Drive Langhorne, PA 19047

SUBJECT: Verification of Information Supplied by an Applicant/Tenant for Housing Assistance

NAME: _____

ADDRESS: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown below.

Area to be completed by Financial Organization

(Please answer all questions. Answer N/A if the question doesn't apply.)

Checking Account

Account # _____ Average Balance for Previous Six (6) Months: $_____ Interest Rate: _____ Date Account Opened: _____ Date Account Closed: _____

Account # _____ Average Balance for Previous Six (6) Months: $_____ Interest Rate: _____ Date Account Opened: _____ Date Account Closed: _____

Savings Account

Account # _____ Current Balance: $_____ Interest Rate: _____ Date Account Opened: _____ Date Account Closed: _____

Account # _____ Current Balance: $_____ Interest Rate: _____ Date Account Opened: _____ Date Account Closed: _____

Certificates of Deposit

Account # _____ Current Value _____ Rate of Interest: _____ Cash Value* _____

**Cash value is the current value minus penalties for early withdrawal or cost to convert to cash (broker fees, etc.)*

Account # _____ Current Value _____ Rate of Interest: _____ Cash Value* _____

**Cash value is the current value minus penalties for early withdrawal or cost to convert to cash (broker fees, etc.)*

Account # _____ Current Value _____ Rate of Interest: _____ Cash Value* _____

**Cash value is the current value minus penalties for early withdrawal or cost to convert to cash (broker fees, etc.)*

Money Market

Account # _____ Current Value _____ Rate of Interest: _____ Cash Value* _____

**Cash value is the current value minus penalties for early withdrawal or cost to convert to cash (broker fees, etc.)*

_____ _____ _____

Name and Title of Person Supplying the Information | Firm/Organization Name | Signature | Date

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would required the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

X_____ X_____

Signature | Date

NOTE TO APPLICANT/TENANT: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208(a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

Please return the form to the address listed above. Thank You.

Acceptable forms of an Asset Verification:

NOTE: HUD accepts three methods of verification. These are, in order of acceptability, third-party verification, review of documents, and family certification. If third-party verification is not available, owners must document the tenant file to explain why third-party verification was not available.

1. Asset verification form completed by a financial institution, broker, etc., indicating the current value of the assets and penalties or reasonable costs to be incurred in order to convert non-liquid assets into cash, or the cash value of the asset. Use current balance in savings account and average monthly balance in checking accounts for last 6 months.

   NOTE: When financial institutions charge a fee to the applicant or tenant for providing verifications, the forms of verification in paragraph below would be the preferred method.

2. Account statements, passbooks, broker's quarterly statements showing value of stocks or bonds, etc., and the earnings credited to the applicant's account statements, or financial statements completed by a financial institution or broker;

   NOTE: The owner must adjust the information provided by the financial institution to project earnings expected for the next 12 months.

Tenant Consent to Disclose EIV Income Information

Print name of tenant authorizing release	*Print name of third party being authorized to view information*

A. Third party to view and/or discuss information for the sole purpose of recertification assistance is an:

- ☐ Adult Household Member
- ☐ Translator / Interpreter
- ☐ Service Coordinator
- ☐ Guardian
- ☐ Temporarily Absent Family Member
- ☐ Individual Assisting Elderly Individual or Person with a Disability
- ☐ Other Individual (Include Relationship): _____

B. Enterprise Income Verification (EIV) information to be viewed and/or discussed for the sole purpose of recertification assistance:

- ☐ EIV Income Report
- ☐ EIV Income Discrepancy Report
- ☐ EIV No Income Report
- ☐ EIV New Hires Report
- ☐ Other EIV information: _____

C. Penalties for Misuse of Information:

The following federal law prohibits the misuse of the information viewed or discussed pursuant to this consent and certification. Tenants, authorized third parties, and HUD or authorized entities employees may be subject to these penalties.

"[W]hoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully - (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both. If the matter relates to an offense under chapter 109A, 109B, 110, or 117, or section 1591, then the term of imprisonment imposed under this section shall be not more than 8 years." 18 U.S.C. 1001.

"Any officer or employee of an agency, who by virtue of his employment or official position, has possession of, or access to, agency records which contain individually identifiable information the disclosure of which is prohibited by this section or by rules or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000. 5 U.S.C. 552a(i).

"The Secretary [of Health and Human Services] shall require the imposition of an administrative penalty (up to and including dismissal from employment), and a fine of $1,000, for each act of unauthorized access to, disclosure of, or use of, information in the National Directory of New Hires established under subsection (i) of this section by any officer or employee of the United States or any other person who knowingly and willfully violates this paragraph." 42 U.S.C. 653(l).

Federal law also provides penalties for misusing Social Security numbers. 42 U.S.C. 408 (a) (6), (7) and (8).

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use.

D. Certifications:

I hereby authorize the third party listed on this consent to view and/or discuss the EIV information identified above for the sole purpose of assisting in the recertification of my housing assistance in accordance with the rights afforded to me by the Privacy Act of 1974. I understand further use of such information is prohibited by the Privacy Act and Social Security Act, and that it may not be disclosed, redisclosed, copied, duplicated, or removed from the property for any reason. I also have read and understand the penalties for such misuse of the information, as provided on this form.

_____	_____	_____
Signature of tenant authorizing release	*Printed name of tenant authorizing release*	*Date*

I hereby acknowledge and certify that I am permitted to view and discuss tenant information pertaining to the above named individual for the sole purpose of assisting the tenant in the recertification of his/her subsidy. I understand further use of such information is prohibited by the Privacy Act and Social Security Act, and that it may not be disclosed, redisclosed, copied, duplicated, or removed from the property for any reason. I also have read and understand the penalties for such misuse of the information, as provided on this form.

_____	_____	_____
Signature of authorized third party	*Printed name of authorized third party*	*Date*

EQUAL HOUSING OPPORTUNITY

We Do Business In Accordance With the Federal Fair Housing Law
(The Fair Housing Amendments Act of 1988)

Property Name: _____

Federal law requires us to obtain criminal background and sex offender registration information for all adult household members applying for assisted housing. To enable us to do this, all household members age 18 or older must answer the questions below. The questions regard drug-related, sex offender and other criminal activity that could adversely affect the health, safety or welfare of other residents. Failure to provide complete and accurate information will result in the rejection of the application.

1. Have you been evicted from a federally-assisted site for drug-related criminal activity within the past three years? □ Yes □ No

2. Do you currently use illegal drugs or abuse alcohol? □ Yes □ No

3. Are you currently subject to a lifetime registration requirement under a state sex offender registration program? □ Yes □ No

4. Have you been convicted of any drug-related crime within the past five years? □ Yes □ No

5. Have you been convicted of any felony within the past five years? □ Yes □ No

6. Have you been convicted of any crime involving fraud or dishonesty within the past five years? □ Yes □ No

7. Have you been convicted of any crime involving violence within the past five years? □ Yes □ No

8. Are you currently charged with any of the above criminal activities? □ Yes □ No

9. Please list all states in which you currently and have previously resided.

_____

_____

10. Have you ever used or been known by any other name? □ Yes □ No
If yes, please list the name(s) used: _____

PENALTY OF PERJURY CLAUSE

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understands that providing false representation herein constitutes an act of fraud. False, misleading or incomplete information may result in the denial of subsidy, termination of the lease agreement and referral to the U.S. Inspector General's office.

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government, HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violation of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

Applicant's Signature _____ Date _____

Applicant's Name (Print) _____

_____ does not discriminate on the basis of handicap status in the admission or access to, or treatment or employment in, its federally assisted properties, programs and activities.

The following person has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development's regulations implementing Section 504: _____
_____

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

DO/BO CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form SSA-827, "Authorization to Release Medical Information to the Social Security Administration," attached.

☐ I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S SIGNATURE *(Required only if Form SSA-827 is NOT attached*	DATE

A. IDENTIFYING INFORMATION

CLAIMANT'S NAME	CLAIMANT'S SSN – –	CLAIMANT'S PHONE NUMBER
CLAIMANT'S ADDRESS	CLAIMANT'S DATE OF BIRTH	MEDICAL SOURCE'S NAME

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES: *Please check if applicable.*

BACTERIAL INFECTIONS

1. ☐ **MYCOBACTERIAL INFECTION,** (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **PULMONARY TUBERCULOSIS**, resistant to treatment
3. ☐ **NOCARDIOSIS**
4. ☐ **SALMONELLA BACTEREMIA,** recurrent non-typhoid
5. ☐ **SYPHILIS OR NEUROSYPHILIS,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

FUNGAL INFECTIONS

7. ☐ **ASPERGILLOSIS**
8. ☐ **CANDIDIASIS,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
9. ☐ **COCCIDIOIDOMYCOSIS,** at a site other than the lungs or lymph nodes
10. ☐ **CRYPTOCOCCOSIS,** at a site other than the lungs (e.g., cryptococcal meningitis)
11. ☐ **HISTOPLASMOSIS,** at a site other than the lungs or lymph nodes
12. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

13. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS,** with diarrhea lasting for 1 month or longer
14. ☐ **PNEUMOCYSTIS CARINII PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINII INFECTION**
15. ☐ **STRONGYLOIDIASIS,** extra-intestinal
16. ☐ **TOXOPLASMOSIS,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS

17. ☐ **CYTOMEGALOVIRUS DISEASE,** at a site other than the liver, spleen, or lymph nodes
18. ☐ **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis,esophagitis, or encephalitis); or disseminated infection
19. ☐ **HERPES ZOSTER,** disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

21. ☐ **HEPATITIS,** resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS

22. ☐ **CARCINOMA OF THE CERVIX,** invasive, FIGO stage II and beyond

23. ☐ **KAPOSI'S SARCOMA,** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

24. ☐ **LYMPHOMA** of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease)

25. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANUS**

SKIN OR MUCOUS MEMBRANES

26. ☐ **CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES,** with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES

27. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months

28. ☐ **GRANULOCYTOPENIA,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months

29. ☐ **THROMBOCYTOPENIA,** with platelet counts repeatedly below 40,000/mm^3 with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months

NEUROLOGICAL ABNORMALITIES

30. ☐ **HIV ENCEPHALOPATHY,** characterized by cognitive or motor dysfunction that limits function and progresses

31. ☐ **OTHER NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in 2 extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME

32. ☐ **HIV WASTING SYNDROME,** characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38° C (100.4°F) for the majority of 1 month or longer

DIARRHEA

33. ☐ **DIARRHEA,** lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY

34. ☐ **CARDIOMYOPATHY** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY

35. ☐ **NEPHROPATHY,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN 1 YEAR

36. ☐ **SEPSIS**

37. ☐ **MENINGITIS**

38. ☐ **PNEUMONIA** (non-PCP)

39. ☐ **SEPTIC ARTHRITIS**

40. ☐ **ENDOCARDITIS**

41. ☐ **SINUSITIS,** radiographically documented

NOTE: If you have checked any of the boxes in section C, proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION

42. a. **REPEATED MANIFESTATIONS OF HIV INFECTION**, including diseases mentioned in section C, items 1-41, but without the specified findings described above, or other diseases, resulting in significant, documented, symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Please specify:

1. The manifestations your patient has had;
2. The number of episodes occurring in the same 1-year period; and
3. The approximate duration of each episode.

Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same 1-year period. (See attached instructions for the definition of repeated manifestations.)

If you need more space, please use section E.

MANIFESTATIONS:	NO. OF EPISODES IN THE SAME 1 YEAR PERIOD	DURATION OF EACH EPISODE
EXAMPLE: Diarrhea	3	1 month each

AND

b. **ANY OF THE FOLLOWING:**

☐ Marked restriction of **ACTIVITIES OF DAILY LIVING**; or

☐ Marked difficulties in maintaining **SOCIAL FUNCTIONING**; or

☐ Marked difficulties in completing tasks in a timely manner due to deficiencies in **CONCENTRATION, PERSISTENCE, OR PACE.**

E. REMARKS: *(Please use this space if you lack sufficient room in section D or to provide any other comments you wish about your patient.)*

F. MEDICAL SOURCE'S NAME AND ADDRESS *(Print or type)*

TELEPHONE NUMBER (Area Code)

DATE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

G.SIGNATURE AND TITLE (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

▶

FOR OFFICIAL USE ONLY

☐ FIELD OFFICE DISPOSITION:

☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4814-F5
(Medical Report On Adult With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

Your patient, identified in section A of the attached form, has filed a claim for Supplemental Security Income disability payments based on HIV infection. **MEDICAL SOURCE:** Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

IF YOU COMPLETE AND RETURN THE ATTACHED FORM PROMPTLY, YOUR PATIENT MAY BE ABLE TO RECEIVE PAYMENTS WHILE WE ARE PROCESSING HIS OR HER CLAIM FOR ONGOING DISABILITY PAYMENTS.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Determination Services will contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

An SSA medical release (an SSA-827) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient and section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS COMPLETE SECTION B.**
- **COMPLETE SECTION C, IF APPROPRIATE.** If you check at least one of the items in section C, go right to section E.
- **ONLY COMPLETE SECTION D IF YOU HAVE NOT CHECKED ANY ITEM IN SECTION C.** See the special information below which will help you to complete section D.
- **COMPLETE SECTION E IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).**
- **ALWAYS COMPLETE SECTIONS F AND G. NOTE: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form, as soon as possible, in the return envelope provided.
- If you received the form from your patient without a return envelope, give the completed, signed form back to your patient for return to the SSA field office.

VI. SPECIAL INFORMATION TO HELP YOU COMPLETE SECTION D:

HOW WE USE SECTION D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

SPECIAL TERMS USED IN SECTION D

WHAT WE MEAN BY "REPEATED" MANIFESTATIONS OF HIV INFECTION: (See Item 42.a)

"Repeated" means that a condition or combination of conditions:

- Occurs an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or
- Does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- Occurs less often than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

WHAT WE MEAN BY "MANIFESTATIONS OF HIV INFECTION": (See Item 42.a)

"Manifestations of HIV infection" may include:

- Any condition listed in section C, but without the findings specified there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or
- Any other condition that is not listed in section C (e.g., oral hairy leukoplakia, myositis).

Manifestations of HIV must result in significant, documented, symptoms and signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Continued on the reverse ⟶

WHAT WE MEAN BY "MARKED" LIMITATION OR RESTRICTION IN FUNCTIONING: (See Item 42.b)

When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.

A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING": (See Item 42.b)

Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

EXAMPLE: An individual with HIV infection who, because of symptoms such as pain, imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

WHAT WE MEAN BY "SOCIAL FUNCTIONING": (See Item 42.b)

Social functioning includes the capacity to interact appropriately and communicate effectively with others.

EXAMPLE: An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty maintaining social functioning.

WHAT WE MEAN BY "COMPLETING TASKS IN A TIMELY MANNER": (See Item 42.b)

Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.

EXAMPLE: An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security Programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore*

UNDER $5,000 / ZERO ASSET CERTIFICATION

(For households whose <u>combined</u> net assets do not exceed $5000)

Household Name:_____ Property and Unit #:_____

Complete all those that apply for 1 through 3:

1. My/our assets include:

Source of Asset	Cash Value*	Interest or Dividend Rate	Annual Income
Checking / Money Market Account	$	%	$
Savings / Certificate of Deposits (CD)			
Stocks / Bonds			
IRA / Keough / 401(k)			
Trust / Retirement / Pension Funds			
Other Retirement			
Equity in Real Estate / Land Contracts			
Life Insurance Policies (excluding term)			
Lump Sum Receipts			
Capital Investments			
Personal Property ** held as an Investment			
Cash on Hand / Safety Deposit Box			
Assets disposed of for less than Fair Market Value within the past two (2) years (see question # 2 below).			
Other (list)			
TOTAL	$		$

*Cash value is defined as market value minus the cost of converting the asset to cash, such as broker's fees, settlement costs, outstanding mortgage, early withdrawal penalties, etc.

**Personal property held as an investment may include, but is not limited to, gem or coin collections, art, antique cars, etc. Do not include necessary personal property such as, but not necessarily limited to, household furniture, daily-use autos, clothing, assets of an active business, or special equipment for use by the disabled.

PLEASE NOTE: Certain funds (e.g., Retirement, Pension, Trust) may or may not be [fully] accessible to you. Include only those amounts that are.

2. π Yes π No Within the past two (2) years I/we have sold or given away assets (including cash, real estate, etc.) for more than $ 1,000 below its fair market value (FMV). If yes, the difference between the FMV and the amount received is referenced in the chart above and a separate Divestiture of Assets form has been completed.

3. π I/we do not have any assets at this time.

The net family assets (as defined in 24 CFR 813.102) above do not exceed $5,000. The annual income from these assets as determined above is included in the total gross annual income.

Under penalty of perjury, I/we certify that the information presented in this certification is true and accurate to the best of my/our knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

_____ _____ _____ _____

Applicant / Tenant Date Applicant / Tenant Date