

MOBRIDGE HOUSING & REDEVELOPMENT COMMISSION

202 Ave E, PO Box 370, Mobridge, SD 57601

Phone: 605/845-2560 Fax: 605/845-9902

TENANT CHANGE REPORT FORM

(Please report all changes prior to the 25th of the month to allow proper time to verify information)

NO CHANGES WILL BE ACCEPTED UNLESS REPORTED ON THIS FORM, AND YOU MUST SUPPLY THE

APPROPRIATE DOCUMENTS REGARDING THE CHANGE(S)

Head of Household Name Address
Print Name (Person completing form) Social Security Number Email Address
Home Phone / Cell Phone Date

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

A. NEW INCOME: Permanent Temporary Seasonal

Name of family member with change

Type of income (Ex: wage, child support, SS, SSI, etc.)

Amount

receiving How often received Date when family member started receiving new income

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

Employer Employer Phone

Employer Address Starting Date

B. INCREASE OR DECREASE IN CURRENT INCOME

Name of family member with change

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

WAGE - Increase Decrease HOUR w Increase Decrease

New amount

receiving How often received Date when the increase/decrease started

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

Employer

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

**c. TERMINATION OF INCOME**

Name of family member with change \_\_\_\_\_

Type of income terminated (wage, child support, SS, SSI, etc) \_\_\_\_\_

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

Employer Employer address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Last date of employment \_\_\_\_\_

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**D. CHANGE OF FAMILY MEMBERS**

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

<u>Legal Name</u>	<u>Relation</u>	<u>Age</u>	<u>Sex</u>	<u>Birthdate</u>	<u>Ejrthplace</u>
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1. \_\_\_\_\_ SS# \_\_\_\_\_

2. \_\_\_\_\_ SS# \_\_\_\_\_

3. \_\_\_\_\_ SS# \_\_\_\_\_

Date Moved In: \_\_\_\_\_

Date Moved Out: \_\_\_\_\_

**E. CHANGE IN CHILDCARE COSTS**

I have these childcare costs:

Name of childcare provider \_\_\_\_\_

Address of childcare provider \_\_\_\_\_

Cost of childcare \_\_\_\_\_

How often paid \_\_\_\_\_

Name of children in childcare \_\_\_\_\_

Amount of childcare reimbursement (if any) \_\_\_\_\_

\_\_\_\_\_ I no longer pay childcare costs. Date last paid for childcare \_\_\_\_\_

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**F. CHANGE IN MEDICAL EXPENSES**

I have the following changes in medical expenses:

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I no longer have the following medical expenses:

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**G. NAME CHANGE**

Current Name

Chan in To

Date of Chan e

**COMMENT SECTION (for office use only)**

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My answers on this form are correct and complete to the best of my knowledge. I understand that I will be required to provide documentation verifying all statements. In addition, the signatures below constitute consent for Mobridge Housing to contact any agencies, organizations, offices, or individuals necessary to verify any information needed for my/our participation in the housing assistance programs,

I am re uired to re ort all chan es within 10 da s of the date of chan e

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Signature

Date

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**AUTHORIZATION FOR RELEASE OF  
INFORMATION Mobridge Housing & Redevelopment  
Commission 202 1<sup>st</sup> Ave E.  
Mobridge, SD 57601.**

Phone: (605) 845-2560 Fax: (605)-845-9902 CONSENT:

I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to Mobridge Housing any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under Section 8, Rental Rehabilitation, Low Income Public Housing, and/or other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies.

**INFORMATION COVERED:**

I understand that, depending on program policies and requirements, previous or current information regarding my household or me may be needed. Verifications and inquires that may be requested, include but are not limited to:

Identity and Marital Status

Employment, Income and Assets

Medical or Child Care Allowances Credit and Criminal Activity Residence and

Rental Activity

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility and for continued participation in a housing assistance program.

**GROUPS OR INDIVIDUALS THAT MAY BE ASKED:**

The groups or individuals that may be asked to release the above information (depending on program requirements) includes but are not limited to:

- |  |                                     |
|--|-------------------------------------|
| Previous Landlords (including<br>(Public Housing Agencies) | Past and Present Employers          |
| Courts and Post Offices                                    | Credit Providers and Credit Bureaus |
| Schools and Colleges                                       | State Unemployment Agencies         |
| Law Enforcement Agencies                                   | Social Security Administration      |
| Support and Alimony Providers                              | Medical and Child Care Providers    |
| Retirement System  | Veterans Administration             |
| Welfare Agencies   | Banks and Financial Institutions    |
|  | Utility Companies                   |

**CONDITIONS:**

I agree that a photocopy of this authorization may be used for the purpose stated above. The original of the authorization is on file with MHRC and will stay in effect for a year and one month from the date signed. I understand that I have a right to review my file and correct any information that I can prove is incorrect.

**WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.**

_____	_____	_____
Head of Household Signature	(Print Name)	Date
_____	_____	_____
Spouse Signature	(Print Name)	Date
_____	_____	_____
Adult Member Signature	(Print Name)	Date