AFFIDAVIT OF ASSETS LESS THAN $5,000

I,_____, have applied for assistance through the Housing Assistance Program. Program regulations require verification of all income and assets from participating households.

I have applied for assistance under the _____ program, on _____.
Date

I have stated during this verification process that my assets total less than $5,000.

Income and assets include but are not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the STRMU/PHP/COVID-19 assistance programs, and may be grounds fortermination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: _____ Date: _____

Witness: _____ Date: _____

Case Manager/Care Coordinator's Notes: