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DEDUCTION QUESTIONNAIRE CERTIFICATION

DEVELOPMENT NAME:______________________________

RE:______________________________

DATE:__________________ **APT#:**______________

Check YES or NO for each statement.

☐ YES ☐ NO 1. Do you have child care expenses for your children aged 12 and under?

Name of Provider:____________________ Phone #:______________

☐ YES ☐ NO 2. Are you receiving assistance to help pay for your child care expenses?

From whom?:____________________ Phone #:______________

☐ YES ☐ NO 3. Are you or your spouse elderly (over 62) and/or do you or your spouse qualify for the $400 deduction available to residents with a handicap or disability?

If your answer to #3 is NO, Stop Here.

Do you have:

☐ YES ☐ NO 4. Medical Insurance premiums?

Name of Company:____________________ Subscriber #:______________

☐ YES ☐ NO 5. Outstanding medical bills or medical bills anticipated in the next 12 months?

Name of Doctor/Clinic/Hospital:____________________________

☐ YES ☐ NO 6. Prescriptions? Name of Pharmacy:______________ Phone#:______________

☐ YES ☐ NO 7. Are you reimbursed for prescriptions through your insurance?

☐ YES ☐ NO 8. Are you reimbursed for prescriptions through any other agency/organization?

☐ YES ☐ NO 9. Other? (Hearing Aid, Glasses, Ambulance, Dental, etc.) List: ______________

____

☐ YES ☐ NO 10. Do you pay expenses for the care of a disabled family member while you work? Include expenses that allow a disabled adult to work.

Paid to whom?____________________________

I hereby certify that the information above is true and complete to the best of my knowledge.

Applicant/Resident Signature	Applicant/Resident Signature
Print Name	Print Name
Date	Date

OFFICE USE ONLY:

We encourage and support the nation's affirmative housing program in which there are no barriers to obtaining housing because of race, color, religion, sex, national origin, handicap or familial status.

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