Date Stamp Here
{Office Use Only}

Time: _____ Rec. By:_____

The Klamath Tribes

Housing Department

UPDATE/CHANGE REPORT

HEAD OF HOUSE HOLD:

NAME: _____ Social Security #:_____
Last First Middle

Address: _____
Mailing City State Zip Code

Telephone #: _____Message #:_____ Klamath Tribal Roll #:_____

Household Members	Date of birth	Social Security #	Relationship to Head of Household	Roll #
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		
		- -		

**** Please explain the change/update in your household? {Change in income, change in household composition, change in address, etc.}**

If you are reporting changes due to adding a <u>new family member</u>, please complete the following:

1. Are you adding a new family member? ☐Yes ☐No
Name: _____ Name of absent parent: _____
2. Has the added member ever lived in Federal Assisted Housing before?
☐Yes ☐No Explain:_____
3. Do they owe any money to KTHD or any other Housing Authorities?
☐Yes ☐No Explain:_____
4. Have they ever-committed fraud in a Federal Assisted housing program?
☐Yes ☐No Explain:_____
5. Have they ever-engaged in drug-related or violent criminal activities?
☐Yes ☐No Explain:_____
6. Have they ever been convicted of any crime? ☐Yes ☐No
Explain:_____

501 Chiloquin Blvd. – P.O. Box 436 – Chiloquin, Oregon 97624
(541) 783-2219 – Fax (541) 783-3994

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If you are reporting change in household income please complete the following:
1. Did income stop, start, change? (Please provide documentation) ☐Yes ☐No

Please list <u>all</u> income for <u>all</u> household members who receive wages - full time, part time, temporary, self-employment, Welfare, SSI/SSD/SSB, Social Security, pension, Disability, Worker's Comp, Unemployment, Alimony, Child Support, per capita, etc.

Household Member	Income Source	Phone #/ Address of source	HR/Monthly/Annually

CHILD CARE FAMILIES ONLY:
Do you pay for childcare? (Please provide documentation) ☐Yes ☐No
Cost per hour: $_____ Total cost per week: $_____ or month: $_____

Does Welfare help pay? ☐Yes ☐No Your co-pay: $_____

Childcare provider name: _____

Telephone #: _____Address: _____

ELDERLY/DISABLED FAMILIES ONLY:

Do you have Medicaid/Medicare? ☐Yes ☐No If yes: What are your premiums? _____

Do you have any other kind of insurance? ☐Yes ☐No

If yes: Insurance Name: _____ Policy # _____

Address: _____ Premium Amount $: _____

Does the state pay any of your medical expenses? ☐Yes ☐No

Do you make payments to a doctor, hospital, or pharmacy? ☐Yes ☐No

Name: _____ Address: _____List any other

out of pocket medical expenses: _____

I certify that all the information provided on this form is accurate and complete to the best of my knowledge. I also understand that all changes in household composition or household income must be reported to the KTHD in writing within 14 days of change. I understand the Title 18, Section 1001 of the U.S. Code, state that a person is guilty of a felony for knowingly and willingly makes false or fraudulent statements to any department or agency of the United States.

_____ _____

Signature of Head of Household: Date: Signature of Other Adult: Date:

_____ _____

Signature of Spouse/Other Adult: Date: Signature of Other Adult: Date: