



Charles County Government  
**DEPARTMENT OF COMMUNITY SERVICES**

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**PRELIMINARY APPLICATION  
 HOUSING CHOICE VOUCHER PROGRAM  
 P R I N T**

**Household Composition and Characteristics:**

Complete this chart for each member of your household who will be living with you under subsidy. **Enter the name of the person who will be head of household under subsidy first.** Give the relationship of each family member to the head of household. Be sure to include yourself. If a baby is expected within nine months, enter "unborn" as the last household member.

| HOUSEHOLD MEMBER'S FULL NAME: |            | MIDDLE INITIAL | RELATIONSHIP | DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER |
|-------------------------------|------------|----------------|--------------|---------------|-----|------------------------|
| LAST NAME                     | FIRST NAME |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |
|                               |            |                |              |               |     |                        |

\*\*USE SEPARATE SHEET FOR ADDITIONAL HOUSEHOLD MEMBERS

**Current Housing Status:**

Current Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_

Physical Address (no PO Box): \_\_\_\_\_  
 \_\_\_\_\_

Contact Information: Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Friend/Relative # \_\_\_\_\_ E-mail: \_\_\_\_\_

**Reasonable Accommodation**

Is anyone in your household handicapped or disabled? \_\_\_\_\_ No \_\_\_\_\_ Yes

Name of the Disabled Household Member: \_\_\_\_\_

What special type of accommodation is requested? \_\_\_\_\_  
 \_\_\_\_\_

**Your Charles County Connection...**

Aging & Senior Programs • Housing Authority • Recreation • Transportation & Community Programs

8190 Port Tobacco Road, Port Tobacco, MD 20677 • 301-934-9305 • 301-932-6004 • 301-870-3388

Fax: 301-934-5624 • E-Mail: Webmail@CharlesCounty.org

Maryland Relay Service: 711 • Relay Service TDD: 1-800-735-2258 • Equal Opportunity County

Visit us online at [www.CharlesCounty.org](http://www.CharlesCounty.org)



CHARLES COUNTY MARYLAND  
 Where Eagles Fly

**Household Income Status:**

Complete this chart for each member of your household who has a source of income. Income includes wages, salaries, commissions, tips, bonuses. Social Security Benefits, SSI, pensions, annuities, disability and death benefits, Veterans Benefits, Unemployment Benefits, Worker's Compensation, Social Service Grants, alimony, child support, independent support payments, Earned Income Tax Credits, interest income and dividends. Provide the gross amount and rate of each source of income. If you need special accommodations to review this information please call Jill Swanson at 301-934-0112.

| NAME | SOURCE/TYPE OF INCOME<br>(employment, pension, SSI, TCA) | AMOUNT OF INCOME | RATE<br>(hourly, monthly) |
|------|--|------------------|---------------------------|
|      |  |                  |                           |
|      |  |                  |                           |
|      |  |                  |                           |
|      |  |                  |                           |

Have you ever participated in a Federal Housing Assistance Program?  No  Yes If yes, complete below:

| PLACE (address)<br>OF PARTICIPATION | TYPE of PROGRAM<br>(S8- Sect 236-Other) | DATE<br>(Mo/Year) | REASON ASSISTANCE ENDED |
|-------------------------------------|---|-------------------|-------------------------|
|                                     |   |                   |                         |
|                                     |   |                   |                         |

**For Statistical Purposes Only:**

Race of Head of Household:

- White  Black  American Indian or Alaskan Native  Asian or Pacific Islander

Ethnicity of Head of Household:

- Hispanic  Non-Hispanic

**Local Preference for Federal Housing Assistance**

Place an "X" in each box that applies to you: ( ) I am a Charles County resident ( ) I am employed in Charles County

YOU WILL BE REQUIRED TO VERIFY YOUR HOUSEHOLD COMPOSITION AND HOUSEHOLD INCOME AT THE TIME YOUR NAME REACHES THE TOP OF THE WAITING LIST. IF YOU ARE UNABLE TO DO SO, YOU MAY BE DETERMINED NOT ELIGIBLE, AND YOUR NAME WILL BE REMOVED FROM THE WAITING LIST. THOSE UNABLE TO VERIFY LOCAL PREFERENCE WILL BE SKIPPED UNTIL ALL OTHERS ON WAITING LIST WITH A LOCAL PREFERENCE HAVE BEEN PROCESSED.

IF FUNDS ARE NOT AVAILABLE FOR ASSISTANCE, YOUR PRELIMINARY APPLICATION WILL BE KEPT ON FILE AND CONSIDERED FOR ASSISTANCE WHEN FUNDS BECOME AVAILABLE AND ACCORDING TO PROGRAM SELECTION CRITERIA. IN ORDER TO KEEP YOUR APPLICATION CURRENT, PLEASE NOTIFY THIS OFFICE, **IN WRITING**, TO REPORT ANY CHANGES IN MAILING ADDRESS OR HOUSEHOLD COMPOSITION.

THIS APPLICATION IS AN INFORMATION SHEET AND DOES NOT CONSTITUTE ANY COMMITMENT BY CHARLES COUNTY COMMUNITY SERVICES FOR RENTAL ASSISTANCE OR FORMAL CORRESPONDENCE.

**APPLICANT CERTIFICATION:**

I/We certify that the information provided to the Charles County Department of Community Services Housing Division on the preliminary application for participation in the Housing Choice Voucher Program is true and complete to the best of my/our knowledge.

\_\_\_\_\_  
SIGNATURE OF HEAD OF HOUSEHOLD / DATE

\_\_\_\_\_  
SIGNATURE OF CO-HEAD / DATE

F:\HCD program files\Rental Subsidy\Section 8\Forms\preliminary application revised.wpd

*8190 Port Tobacco Road, Port Tobacco, Maryland 20677  
301-934-9305 \* 301-932-6004 \* 301-870-3388 \* FAX: 301-934-5624  
MD Relay Service: 711 \* Relay Service TDD: 1-800-735-2258  
[WWW.CHARLESCOUNTY.ORG](http://WWW.CHARLESCOUNTY.ORG)  
Equal Opportunity County \* Say No to Drugs*

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

**SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING**

This form is to be provided to each applicant for federally assisted housing

**Instructions: Optional Contact Person or Organization:** You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

|  |  |
|--|--|
| <b>Applicant Name:</b>   |  |
| <b>Mailing Address:</b>  |  |
| <b>Telephone No:</b>   | <b>Cell Phone No:</b>  |
| <b>Name of Additional Contact Person or Organization:</b>  |  |
| <b>Address:</b>  |  |
| <b>Telephone No:</b>   | <b>Cell Phone No:</b>  |
| <b>E-Mail Address (if applicable):</b>   |  |
| <b>Relationship to Applicant:</b>  |  |
| <b>Reason for Contact:</b> (Check all that apply)  |  |
| <input type="checkbox"/> Emergency   | <input type="checkbox"/> Assist with Recertification Process |
| <input type="checkbox"/> Unable to contact you   | <input type="checkbox"/> Change in lease terms               |
| <input type="checkbox"/> Termination of rental assistance  | <input type="checkbox"/> Change in house rules               |
| <input type="checkbox"/> Eviction from unit  | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Late payment of rent  |  |
| <b>Commitment of Housing Authority or Owner:</b> If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.   |  |
| <b>Confidentiality Statement:</b> The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.  |  |
| <b>Legal Notification:</b> Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975. |  |

Check this box if you choose not to provide the contact information.

|  |  |
|--|--|
|  |  |
|--|--|

**Signature of Applicant**

**Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

**Privacy Statement:** Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.