



Housing Authority of Thurston County
 1206 12th Avenue SE, Olympia WA 98501
 Tel: (360) 753-8292 Fax: (360) 586-0038
 www.hatc.org

UNEMPLOYMENT AFFIDAVIT/CERTIFICATION OF ZERO INCOME

Head of Household: _____
 Participant/Applicant Name: _____ Date: _____

1. I hereby certify that I do not individually receive income from any of the following sources:
- a. Wages from employment (including commissions, tips, bonuses, fees, etc);
 - b. Income from operation of a business;
 - c. Rental Income from real or personal property;
 - d. Interest or dividends from assets;
 - e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
 - f. Public assistance payments (GAU, GAX, TANF, etc);
 - g. Periodic allowances such as alimony, child support, gifts received from persons not living in my household;
 - h. Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc);
 - i. Panhandling, soliciting money from strangers;
 - j. Any other source not named above.

2. I currently have no income of any kind and there is no imminent change expected in my financial status or employment status during the next 3 months.

3. I will be using the following sources of funds to pay for rent and other necessities: _____

4. I have worked in the past 12 months: Yes No

If yes, list where you worked in the past 12 months (if more than one, list on a separate sheet).

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Dates of Employment: From _____ To _____

Amount Earned: _____

5. Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representation herein constitutes an act of fraud. False, misleading, or incomplete information may result in the termination of housing benefits as well as an overpayment recovery.

 Printed Name of Participant/Applicant

 Signature of Participant/Applicant

 Date

In order to continue to offer you a full subsidy, we need clarification on your monthly budget. Please complete, sign, and return this form so that we may re-evaluate your assistance level. Please put NIA next to any item that does not apply and add other living expenses that you have in a typical month that are not listed.

ITEM	DOLLAR AMOUNT NEEDED MONTHLY	SOURCE OF NEEDED ITEM
DAILY FOOD	\$	
BEVERAGES	\$	
CIGARETTES	\$	
CAR PAYMENT	\$	
CAR INSURANCE	\$	
GAS & CAR MAINTENANCE	\$	
PUBLIC TRANSPORTATION	\$	
MEDICAL & DENTAL CARE	\$	
PHONE/CELL PHONE	\$	
CLOTHING	\$	
LAUNDRY	\$	
TOILETRIES, CLEANING SUPPLIES, PERSONAL CARE ITEMS	\$	
RENT PAYMENT	\$	
POWER BILL	\$	
OTHER	\$	

IMPORTANT NOTE: If someone helps you on a regular basis with any or all of the above items, please have that persona complete and submit a Gift Affidavit form. If you routinely use the Food Bank, Other Bank, Bread and Roses, etc., please complete an Emergency Needs Service Provider form.

Section 1001 of Title 18 of the U.S. Code make it a criminal offense to **make** willful false statements or misrepresentations to any Department of Agency of the United States as to any matter within its jurisdiction.

