The Department of Community Housing
Public Rental Housing Program

The Department of Community Housing (DCH) has revised the **GRIC Admissions and Occupancy Policy (A&O)** to better serve the Low-income Gila River Indian Community members. With the revised A&O policy in place, this allows the DCH to accept Low Rental Housing Applications on a daily basis; applications are available for distribution.

To qualify: (All information must be no more than 90 days old):

Completed applications are required to have the following documents upon submission to the Department. It is the applicant's responsibility for obtaining all supporting documentation and must be available at time of submission.

The required documents include the following:

- **MUST** be 18 years of age on the date of application when submitted.
- State Identification for **all** members 18 years of age and older
- Current CDIB (Certified Degree of Indian Blood) for **all** members of the Household
- Social Security Cards for **all** members
- Birth Certificates for **all** members under 18 years of age. (Exceptions for newborns; will accept crib card/bracelet or immunization record until birth certificate is received)
- Proof of Marriage License
- Any form of Legal Identification
- Proof of Guardianship, Power of Attorney and/or other legal documents establishing custody arrangements for children placed in the applicant's home
- Signed "**Consent to Release**" form by **all** members 18 years and older
- Income Verification (**All members of Household**) – Current Check Stub(s) for Employment **Award Letter for**: SSI, SSA-Retirement, Survivors, Child Support,

Application may be turned in at the following DCH locations:

DCH Main Office – Sacaton,
136 South Main Street
Sacaton, Arizona
8 am – 5 pm (M-F)

DCH Westend Office – Komatke,
119 Tashquinth Drive
Laveen, Arizona
8 am -5 pm (M-F)

Family Households are ELIGIBLE at the 80% of (HUD) Area Median Income Level (AMI):

Income Limits Are Subject to Change

FY –2022	United States Median Family Income Limits under the NAHASDA Act of 1996							
HH Size	1	2	3	4	5	6	7	8
80%	$50,400	$57,600	$64,800	$72,000	$77,800	$83,600	$89,300	$95,100

For questions or for more information please contact
Housing Intake Specialist (520) 562-3904
E-mail: DCH.Housing.Services@gric.nsn.us

GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING

Low Rent Housing: Check-Off List

Name: _____ **Submission Date:** _____

Time: _____

	Recvd	Pending	Description
1			Application
2			Applicant/Resident Certification
3			Consent to Release Form (All Household Members over 18-yrs)
4			ID's for all 18 yrs. & Over
5			Social Security Cards (For All House Hold Members)
6			Birth Certificate / Guardianship Letter
7			Current CIB for all Household Members
8			Proof of Marriage License
9			Proof of Guardianship, Power of Attorney
10			Verification of Disability
11			Pay-Stub (past 30-days)
12			Verification of Income Form
13			Per Cap Form or Check Stub
14			Unemployment Form (If Applicable)
15			DES/TSS Verification (If Applicable)
16			DES Unemployment Verification Form
17			Letter of Understanding

Must be completed by each adult listed on the application. (If more than one adult you will need to make copies)

Comments:

_____

_____

_____

_____

_____

Office Use Only:

			Submit Date	Initial	Complete Date	Intial
1		Entered into HDS/Doorways Database				
2		Low Rent Income Worksheet (Excel)				
3		Per Capita Verification				
4		Income Verification				
5		DES Verification				
6		DES Unemployment Verification				

			Submit Date	Initial	Complete Date	Intial
7		Denied				
8		Approved				
9		Letter to Applicant (Eligibility)				

GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMU NITY HOUSING

APPLICATION FOR HOUSING ASSISTANCE
LOW RENT

NAME _____ DATE: _____ TIME: _____

MAILING ADDRESS: _____

TELEPHONE: HOME: _____ CELL: _____
WORK: _____ E-MAIL: _____

Have you ever lived in a HUD Assistant Home under Gila River Housing Authority? ☐Yes ☐No

if Yes, When:_____ Where:_____

Reason for Leaving:_____

1. Family Composition

Persons who will move into unit.

	Family Members	Relation	Birth Date	Age	Sex	S.S.N.	Enrollment No.
1		**H.O.H.**					
2							
3							
4							
5							
6							
7							
8							
9							
10							

Anticipated Change in Family Composition: _____

_____

2. Source of Family Income

Family Member	Name of Business	Business Address	Estimated Yearly Income or Hourly Rate

Total Yearly Family Income… .....$ _____

3. Housing Conditions:

A. Without Housing? YES NO Explain: ______________________________

B. Directions to Present Residence: ______________________________

4. Disabled/Handicapped/Veteran:

A. Member Disabled: ______________________________

B. Member Handicapped: ______________________________

C. Member In Military Service: ______________________________

◆◆

I understand that this is not a contract and does not bind either party. The above information is full, true and complete to the best of my knowledge. I have no objections to inquires being made for the purpose of verifying the statements herein.

Name of Applicant(s): ______________________________ Date: ______________

______________________________ Date: ______________

Interviewed by: ______________________________ Date: ______________

Title: ______________________________

For Office Use Only	
Veteran:	Tribal Member:
Steady Income:	Overcrowded:
Good Credit History:	Police Officer:
Married Couple:	
Eligible: Ineligible:	Total Points:

GRIC - DEPARTMENT OF COMMUNITY HOUSING
P.O. Box 528, 136 South Main Street
Sacaton, Arizona 85147-0528

Phone: (520) 562-3904 Fax (520) 562-3927

APPLICANT/RESIDENT CERTIFICATION

I/We certify that the information given to the D.O.C.H. on household composition, income, net family, assets, citizenship status, allowances and deductions or any other information submitted is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal Law. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

_____ _____

SIGNATURE OF HEAD OF HOUSEHOLD DATE

_____ _____

SIGNATURE OF SPOUSE DATE

If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-Free Hot Line at 800-424-8590. (Within Washington, D.C. Metropolitan area, call 426-3500).

*After verification by this Housing Agency, the information will be submitted to the Department of Housing and Urban Development on Form HUD-50058 (Resident Data Summary), a computer-generated facsimile of the form or on a magnetic tape.

GRIC - DEPARTMENT OF COMMUNITY HOUSING

P.O. Box 528, 136 South Main Street
Sacaton, Arizona 85147-0528

Phone: (520) 562-3904 Fax (520) 562-3927

CONSENT: I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to **GRIC- DEPARTMENT OF COMMUNITY HOUSING** any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Section 8, Rental Rehabilitation, Low-Income Public and Indian Housing, and/or other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies.

INFORMATION COVERED: I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verifications and inquiries that may be requested include but are not limited to:

Identity & Marital Status; Employment, Income, and Assets; Residences and Rental Activity; Medical or Child Care Allowances and Credit and Criminal Activity

I understand that this authorization cannot be used to obtain any information about me that is **not** relevant to my eligibility for and continued participation in a housing assistance program.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED: to release the above information (depending on program requirements) include, but are not limited to:

- Previous Landlords
- Past and Present Employers
- Veterans Administration
- Public Housing Agencies
- Welfare Agencies
- Retirement Systems
- Courts and Post Offices
- State Unemployment Agencies
- Banks and other Financial Institutions
- Schools and Colleges
- Social Security Administration
- Credit providers and Credit Bureaus
- Law Enforcement Agencies
- Medical and Child Care Providers
- Utility Companies
- Support and Alimony Providers

CONDITIONS: I agree that a photocopy of this authorization may be used for the purposes stated above. This authorization will stay in affect for a year and one month from the date signed.

PRIVACY ACT NOTICE

Authority: The GRIC Department of Community Housing (DCH) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older.

Purpose: Your information is being collected by the GRIC Department of Community Housing (DCH) to determine your eligibility and to adequately determine the number of bedrooms needed based on your household composition and size.

Other Uses: To protect the Tribal Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regu latory investigators and prosecutors. However, the information ***will not*** be otherwise disclosed or released outside of the Department of Community Housing (DCH), except as permitted or required by law.

Penalty: Applicants must provide **all** of the information requested by the Department of Community Housing (DCH), including all Social Security Numbers for you and all household members (ages six years and older). Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SUPPLIED IS ACCURATE AND COMPLETE ON MY PREVIOUS RESIDENCY AND CURRENT HOUSEHOLD COMPOSITION.

Signature – Head of Household	Printed Name	Date
Signature – Co-Head	Printed Name	Date
Signature – Other Adult	Printed Name	Date
Signature – Other Adult	Printed Name	Date
Signature – Other Adult	Printed Name	Date

GILA RIVER INDIAN COMMUNITY

Sacaton, Arizona 85147

Enrollment/Census Department
Post Office Box 97
Phone: (520) 562-9790
Fax: (520) 562-8103

Authorization to Release Information Form

Requestor's Name: _____ **GRID# or DOB:** _____

Address: _____ **Phone:** _____

I give authorization to the Enrollment/Census Department to release requested documents for:

☐ **Self** ☐ **Minor Child** ☐ **GRIC Member whom I have legal guardianship of**

NAME	Date of Birth	GRID#

Please release the following:

☐ **Certificate of Indian Blood** ☐ **BIA 4432 Form** ☐ **Game & Fish Wildlife Form** (Eagle Feather) ☐ **Family Tree** (Sent by U.S. Mail)

Delivery Method

☐ **Hold for Pick-Up** ☒ **Mail** ☒ **Fax***

*Original will be mailed to requestor unless otherwise indicated

Send to: (department/agency name,if applicable) Department of Community Housing

Name: _____ **Phone:** (520) 562-3904

Address: P. O. Box 528 **Fax:** (520) 562-3927

City, State, Zip: Sacaton, AZ 85147 **Deadline Date:** _____ (If Applicable)

Requestor's Signature: _____ **Date:** _____

Notarization required if submitted by mail, fax, or a third party

State of: _____)
)
County of: _____)

Subscribed and sworn or affirmed and acknowledged before me this _____day of_____, 20_____ .

MY COMMISION EXPIRES:

(seal)

_____ _____

NOTARY PUBLIC

Enrollment Department Use Only

Received By: _____ **Date:** _____

Completed By/Notes: _____ **Date:** _____

Revised:03/04/2019

GILA RIVER INDIAN COMMUNITY

Department of Community Housing

HOUSING SERVICES – Verification of Disability

Department of Community Housing
P.O Box 528
Sacaton AZ, 85147
Fax #: 520-562-3927

RE: Verification of Disability (please return completed form to above address)

Name: _____ SSN: ____-____-____ DOB: _____

The individual named above is an applicant/tenant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

I, the undersigned, do hereby authorize the release of the information requested to .

Applicant / Tenant Signature: _____ Date: _____
(or see signed Authorization for the Release of Information)

PLEASE VERIFY THE CLAIMED DISABILITY BY THE ABOVE NAMED APPLICANT/PARTICIPANT

For purposes of this verification, the definition of disabled is:
A person who-- (a) Has a disability as defined in section 223 of the Social Security Act (42 U.S.C. 423); or (b) Is determined to have a physical, mental or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions; or (c) Has a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(5)). The term "person with disabilities" does not exclude persons who have the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

Does the applicant meet the above definition of a disabled individual? ___Yes ___No

Comments: _____

_____

Evaluator/Diagnostician Name: _____

Date: _____ Title: _____ Phone: _____

Signature: _____

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

For Office use only: ___Initial ___Annual ___Interim Occupancy Specialist _____

GILA RIVER INDIAN COMMUNITY

Department of Community Housing

HOUSING SERVICES – Verification of Employment

CURRENT EMPLOYER: NAME: _____

_____ ADDRESS: _____

EMPLOYERS NUMBER: _____

_____

The individual named above is an applicant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. The person identified above has informed us that he/she has within the past 12 months been employed by your firm. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

Consent to Release Information *Department of Community Housing*

_____ _____

Applicant Signature Date Housing Services Date

S.S # _____

-DO NOT WRITE BELOW THE LINE-

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Date Hired: _____ **Occupation / Position:** _____

Current Pay Rate: $ _____ **Per:** ☐Hour / ☐ Day / ☐Week / ☐ Month **Effective Date:** _____

Overtime Pay Rate: $ _____ **Per:** ☐Hour / ☐ Day / ☐Week / ☐ Month

ENTER THE NUMBER OF HOURS WORKED DURING THE PAST TWELVE (12) MONTHS:

-Average Hours:-		-Overtime Hours:-	
Per Day: _____	**Per Week:** _	**Per Day:** _____	**Per Week:** _____

-Year to Date:-

Reg Pay: _____ **Overtime:** _ **Tips:** __ **Deposit Tips:** _____

Is Employee on one of the following Leave types? Is the Employee eligible for compensation? Yes ☐ No ☐

(Please check the ones that are applicable)

_____ Leave of Absence:	☐ Yes	☐ No	_____ Short Term Disability:	☐ Yes	☐ No
_____ Family Medical Leave:	☐ Yes	☐ No	_____ Long Term Disability:	☐ Yes	☐ No
_____ Use of Annual and/or Sick Leave:	☐ Yes	☐ No	_____ Approved Donated Leave:	☐ Yes	☐ No

If you answered yes, please complete the following:

Last Day Worked: _____ Last Date Wage(s) received: _____

When is Employee anticipated to Return to Work: _____

Comments: _____

_____

Print Name: _____ Signature: _____

Date: _ Title: _____ Phone: _____

****Please return completed form via email or fax (520) 562-3927****

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

For Office use only: ___Initial ___Annual ___Interim Occupancy Specialist _____

Gary T. Mix
Community Treasurer

Martha A. Notah
Assistant to the Treasurer

GILA RIVER INDIAN COMMUNITY
Office of the Treasurer

"To Ensure and Protect the Integrity of the Community's Funds, Investments and Assets"

AUTHORIZATION TO RELEASE INFORMATION

I, _____ give my authorization to the Gila River Indian Community Service Center and/or Housing Office, to obtain information on my behalf showing that I have or have not received the Per Capita payment that was distributed on:

1/31/___ 4/30/___ 7/31/___ 10/31/___

My Per Capita Office information is:

Gila River ID#: _____

Signature of Release: _____

Contact Phone #: _____ Date: _____
(To be used only if more information is required)

District Service Center or Housing Use Only

Received by: _____ Date: _____

Completed by: _____ Date: _____

Per Capita Office Use Only

Received (stamp here): _____

Verified as follows:

☐ Did ☐ Did not receive 1/31/___ pay-out ☐ Did ☐ Did not receive 4/30/___ pay-out

☐ Did ☐ Did not receive 7/31/___ pay-out ☐ Did ☐ Did not receive 10/31/__ pay-out

PCO Verifier: _____
(Sign & Date)

525 West Gu u Ki • Post Office Box 2160 • Sacaton, Arizona 85147 • Telephone: (520) 562-9685 • Fax Line: (520) 562-9659

GILA RIVER INDIAN COMMUNITY

Department of Community Housing

HOUSING SERVICES – Unemployment Form

I, _____ am currently unemployed at this time. I understand that if I become employed or start receiving unemployment income, I will contact Housing Services within (10) business days. I understand that failure to do so will result in removal of my application.

_____ _____

Applicant Signature **Date**

_____ _____

Housing Services **Date**

Office Hours, Monday-Friday, 8:00 a.m. – 5:00 p.m.

Main Office PO BOX 528 * Sacaton, AZ 85247 * (520) 562-3904 * Fax (520) 562-3927 *
Maintenance Warehouse & Construction Office * (520) 796-4550 * Fax (520) 796-4551 *
West End Office *(520) 796-4555 * Fax (520) 796-4556 *

FAA-1442A FORFF (12-19)

Requestor Agency

GILA RIVER INDIAN COMMUNITY
Department of Community Housing
136 South Main Street
P. O. Box 525
Sacaton, AZ 85147

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
(Administración de Asistencia para Familias)

TRIBAL- AUTHORITY TO RELEASE INFORMATION / AUTORIDAD TRIBAL PARA DIVULGAR INFORMACIÓN

REQUESTOR'S INFORMATION

Name *(Last, First, M.I.) / Nombre (Apellido, Nombre, S.I.)*
Housing Services Program

Phone No. / *Teléfono* (520) 562-3904

FAX No. / *Núm. de FAX* (520) 562-3927

The person whose name and signature appear below has requested your cooperation in releasing the following information. Please complete and return this form within **3 business days** by fax or email.

*La persona cuyo nombre y firma aparecen a continuación ha solicitado su cooperación para divulgar la siguiente información. Por favor, llene y devuelva este formulario dentro de los **3 días habiles** por fax o por correo electrónico.*

AUTHORIZATION TO RELEASE INFORMATION / AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN

I hereby authorize and consent to the release of any and all information requested below concerning myself and my household's members to the requesting party above. The confidentiality of the information furnished will be preserved except where disclosure of this information is required by applicable law.

Por la presente, autorizo y consiento en que se divulge toda y cualquier información que se solicita a continuación acerca de mí y los miembros de mi hogar. Se mantendrá la confidencialidad de la información proporcionada, excepto cuando la ley aplicable exija la divulgación de esta información.

PARTICIPANT'S INFORMATION

Name *(Last, First, M.I.) / Nombre (Apellido, Nombre, S.I.)*

Soc.Sec.No or Date of Birth *(DOB) / Núm.de Seg. Soc. o Fecha de nacimiento*

Mailing Address *(No., Street, City, State, ZIP) / Dirección Postal (Núm. Calle, Ciudad, Estado, C.P)*

AZTECS No. / *Núm.de AZTECS*

Date of Request / Fecha de solicitud

Signature / Firma

PARTICIPANT'S INFORMATION

Name *(Last, First, M.I.) / Nombre (Apellido, Nombre, S.I.)*

Soc.Sec.No or Date of Birth *(DOB) / Núm.de Seg. Soc. o Fecha de nacimiento*

Mailing Address *(No., Street, City, State, ZIP) / Dirección Postal (Núm. Calle, Ciudad, Estado, C.P)*

AZTECS No. / *Núm.de AZTECS*

Date of Request / Fecha de solicitud

Signature / Firma

DES OFFICE USE ONLY, DO NOT WRITE BELOW THIS LINE
SOLO PARA EL USO DEL DES, NO ESCRIBA DEBAJO DE ESTA LÍNEA

Benefit Type Cash Assistance *(CA)* ☐ N/A Monthly Amount $ _____ Expiration / Renewal Date _____

Benefit Type Nutrition Assistance *(NA)* ☐ N/A Monthly Amount $ _____ Expiration / Renewal Date _____

Names of Individuals Included in Case _____

Additional Comments _____

I certify that the information provided is correct to the best of my knowledge.

Name of DES Person Providing Information _____

Signature of DES Person Providing Information _____ Date _____

Title _____ Phone No. _____

See page 2 for USDA/EOE/ADA/LEP/GINA disclosures • Vea la página 2 para leer la declaración USDA/EOE/ADA/LEP/GINA

GILA RIVER INDIAN COMMUNITY

Department of Community Housing

HOUSING SERVICES – Verification of Assistance

Arizona Department of Economic Security
Unemployment Insurance Program
P. O. Box 29225 #5895
Phoenix, AZ 85038-9225

Verification of Unemployment Income (please return completed form to address below)

Name: _____ **SSN:** _____ **DOB:** _____

The individual named above is an applicant/tenant for housing assistance that is subsidized through the U.S. Department of Housing and Urban Development. Federal regulations require that in order for the household to be eligible, we must verify the household's income, expenses and other information using third party written verifications. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be held in strict confidence. **We are required to complete our verification process in a short time period and would appreciate your prompt response to this request for information.**

I, the undersigned, do hereby authorize the release of the information requested to Gila River Department of Community Housing.

Applicant / Tenant Signature: _____ Date: _____
(or see signed Authorization for the Release of Information)

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Unemployment Income

Unemployment Award Amount: $_____ Per: Week / Month (Circle one)

Beginning Date of Payments: _____ Ending Date of Payments: _____

Is client eligible for an extension of benefits? _____Yes _____No

Date applicant/tenant first received benefits: _____

A print out may be attached.

Comments: _____

Date: _____ Title: _____ Phone: _____

Signature: _____

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

For Office use only: ___Initial ___Annual ___Interim Occupancy Specialist _____

GILA RIVER INDIAN COMMUNITY

Department of Community Housing

HOUSING SERVICES – Letter of Understanding

I, _____, understand that I am applying for Low Rent Housing from the Gila River Indian Community (GRIC) Department of Community Housing (DCH).

I understand, if I am denied assistance I will be notified in writing sent via mail to the address provided on the application.

I understand, when selected for a unit it will be based on unit availability; not by District location or preference.

I understand, I am responsible for notifying the Department of Community Housing of any changes to my contact information (for example: phone number, mailing address, etc.).

I understand, this application will require an update in January of every calendar year.

_____ _____

Applicant Signature Date

_____ _____

Housing Services Staff Date

Office Hours, Monday-Friday, 8:00 a.m. – 5:00 p.m.
Main Office PO BOX 528 * Sacaton, AZ 85247 * (520) 562-3904 * Fax (520) 562-3927 *
Maintenance Warehouse & Construction Office * (520) 796-4550 * Fax (520) 796-4551 *
West End Office *(520) 796-4555 * Fax (520) 796-4556 *