



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 applicants 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 - 5:00 pm (M-F)**

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

Income Limits Are Subject to Change

FY - 2026	United States Median Family Income Limits under the NAHASDA Act of 1996							
HH Size	1	2	3	4	5	6	7	8
80%	\$62,950	\$71,950	\$80,950	\$89,900	\$97,100	\$104,300	\$111,500	\$118,700

**For questions or for more information please contact
Housing Intake Specialist
(520) 562-3904**

E-mail: DCH.Housing.Services@gric.nsn.us

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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			Proof of Marriage License
8			Proof of Guardianship, Power of Attorney
9			Verification of Disability
10			Pay-Stub (past 30-days)
11			Verification of Income Form
12			Per Cap Form or Check Stub
13			Unemployment Form (If Applicable)
14			DES/TSS Verification (If Applicable)
15			DES Unemployment Verification Form
16			Conflict of Interest Acknowledgement
17			Letter of Understanding
18			

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:

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
7	GRIC Enrollment Verification
8	SOR Verification

Submit Date	Initial	Complete Date	Initial

7	Denied
8	Approved
9	Letter to Applicant (Eligibility)

Submit Date	Initial	Complete Date	Initial

GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING

APPLICATION FOR HOUSING ASSISTANCE LOW RENT

NAME _____ DATE: _____
ADDRESS: _____ TIME: _____
_____ BEDROOM SIZE: _____
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							

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.



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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 regulatory 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

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: _____

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 *

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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****

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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



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

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)

Requestor Agency

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
(Administración de Asistencia para Familias)TRIBAL- AUTHORITY TO RELEASE INFORMATION
/ AUTORIDAD TRIBAL PARA DIVULGAR
INFORMACIÓNGILA RIVER INDIAN COMMUNITY
Department of Community Housing
P. O. Box 528
Sacaton, AZ 85147

REQUESTOR'S INFORMATION

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

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 hábiles** 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 LÍNEABenefit 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. _____



GILA RIVER INDIAN COMMUNITY

Department of Community Housing HOUSING SERVICES – Verification of Disability



Department of Community Housing
P.O Box 528
Sacaton AZ, 85147
Email: DCH.Housing.Services@gric.nsn.us
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 Department of Community Housing (DCH). 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

Applicant / Tenant Signature: _____ Date: _____

PLEASE CHECK THE APPROPRIATE DEFINITION:

The definition of a disabled person includes a person who meets any one of the following criteria:

- ☐ Has a physical, mental, or emotional impairment that:
1. Is expected to be of long-continued and indefinite duration;
 2. Substantially impedes his or her ability to live independently, and;
 3. Is of such a nature that ability to live independently could be improved by more suitable housing conditions.

- OR -

- ☐ Has a disability as defined in Sec. 223 of the Social Security Act (42 U.S.C. 423):

"Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months," or

"In the case of an individual who has attained the age of 55 and is blind and unable by reason of such blindness to engage in substantial, gainful activity requiring skills or ability comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time."

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

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GILA RIVER INDIAN COMMUNITY

Department of Community Housing HOUSING SERVICES – Verification of Disability



NOTE: Receipt of veteran's disability benefits does not automatically qualify a person as disabled, because the Veterans Administration and Social Security Administration define disabled persons differently. Applicants who meet Social Security's definition of a disabled person are considered disabled even if they do not receive social security benefits.

- OR -

☐

Has a developmental disability as defined in Section 102(8) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)):

"Severe chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is manifested before the person attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitation in three or more of the following areas of major life activity: (1) self-care, (2) receptive and responsive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, and (7) economic self-sufficiency; and (e) reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

Does the applicant meet the above definition of a disabled individual? ____ Yes ____ No

Special Living Accommodations:

Physicians

Name: _____

Date: _____ Title: _____ Phone: _____

Signature: _____

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GILA RIVER INDIAN COMMUNITY

DEPARTMENT OF COMMUNITY HOUSING

CONFLICT OF INTEREST ACKNOWLEDGEMENT



Name: _____

Name of Program Applying for: Low Rent ☐ or Urban Rental Assistance ☐

Date: _____

☐ I am applying for the Department of Community Housing Program noted above and I am disclosing that:

- A. ☐ I am a **DCH employee, Housing Advisory Committee member, or Tribal Council, or GRIC Executive.**
- B. ☐ I am an immediate family member to **DCH, HAC, Tribal Council, or GRIC Executive.**
- C. ☐ I am a business partner, of **DCH employee, or HAC, Tribal Council, or GRIC Executive** member.
- D. ☐ I am neither to all of the above.

If you are a family member of a **DCH, HAC, Tribal Council, or GRIC Executive** member, please state their name, and your relationship to them.

Name	Relationship

I understand that the public disclosure of my selection will be made and that a copy of the disclosure shall be submitted to the Housing and Urban Development if necessary.

I have been notified of my opportunity to receive a copy of the Conflict of Interest Policy or to receive additional information from DCH.

I understand that my disclosure does not disqualify me or determine my application ineligible.

Applicant Signature

Date _____

Other Adult

Date _____

Other Adult

Date _____



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.

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