City of Anderson Community Development

CDBG and HOME Income Verification Application 2021

Effective June 1, 2021

For Office Use Only - Check List of Documents Received:

Staff name (print): _____ Date: _____

Filed a Federal Tax Return for last year and must provide the following:

- ☐ 1040 Federal Tax forms for ALL in the household that filed. I am providing 1040 forms AND most recent 90 days of all income sources

Received assistance and must provide the following:

- ☐ Social Services/DHR Award Letter showing proof of Food Stamps, or TCA/TANF or Temporary Disability.
- ☐ Proof of Child Support
- ☐ Proof of Social Security, SSI or VA
- ☐ Unemployment Compensation Letter
- ☐ Proof of Bank Statements: Last 4 months

OR

Did not file Federal Taxes for last year and must provide the following:

Documents showing most recent 90 days of income from ALL sources.

- ☐ Pay Stubs
- ☐ Letter from Employer
- ☐ Social Services/DHR Award Letter showing proof of Food Stamps, TCA/TANF or Temporary Disability.
- ☐ Proof of Child Support
- ☐ Proof of Social Security, SSI or VA Compensation.
- ☐ Unemployment Compensation Letter AND Proof of Bank Statements: 4 months

The funds available for this program are made possible through the City of Anderson, Community Development Department (CDD), CDBG Program. The Community Development Block Grant (CDBG) Program provides annual grants on a formula basis to states, cities, and counties to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, for **low- and moderate-income persons**. The program is authorized under Title 1 of the Housing and Community Development Act of 1974, Public Law 93-383, as amended 42 U.S.C.-530.1.v. **CDBG and HOME programs require household income qualification. Income verification is required for all adults in a household.** All information will be kept confidential.

At a minimum, file documentation will include:

a) Client name and address b) Gender c) Ethnicity/Race d) Head of household status
e) Income (with copies of source documents/income verification)

Each Sub-recipient or CDHO is required to maintain documentation on clients benefiting from activities, program or projects funded through the City's CDBG and/or HOME programs. As a condition of the HUD grant, the City, and in turn the Sub-recipient or CHDO, must certify that low and moderate income persons are being served. HUD also requires information on the race and ethnic background of the clients, how many are female heads of household, their residency in the City, and how many are very-low income. City CDD staff and HUD must also have access to the names of the clients. Any information regarding applicants for services funded through federal monies shall be held in strict confidence.

Please allow 5-7 days for us to process your application. You will be notified by telephone if your application has been approved or if you need to submit additional information. Financial assistance is awarded on a first come, first serve basis, subject to available resources. All program participants receive the same benefits, regardless of whether or not they are receiving assistance. **If you have any questions please call:**

Name of Organization_____ **Name of Program**_____

Organization Phone #:_____ **Date**_____

Confidential Financial Assistance Application

(Please complete this application entirely. Providing all income verification documents with a complete application will allow us to process your application quickly.

- Who will be the primary applicant? ☐ Individual Adult ☐ Senior Adult (62+)
- Race/Ethnicity of the participant

  (please circle the number by the race/ethnicity that best describes the participant)

  1. White, 2. Black/African American, 3. Asian, 4. American Indian/Alaskan Native, 5. Native Hawaiian/Other Pacific Islander, 6. American Indian/Alaskan Native & White, 7. Asian & White, 8. Black/African American & White, 9. American Indian/Alaskan Native & Black/ African American, 10. Other Multi Racial

- **Household:** How many: _____ Additional Adults _____ Additional Seniors
  _____ Children 0-18 _____ College Students (full time) under 26
  Your application cannot be processed without answering the following questions.
  Please be specific:
  <u>Primary Applicant</u>: Attach income verification documentation
  Name: _____ Social Security#_____
  Date: _____
  Address: _____
  City/State/Zip: _____
  Phone (h): _____ Phone (c): _____
  email_____ Date of Birth: _____
  Employer:_____ Race/Ethnicity:_____

<u>Additional Adults in the Household:</u> Attach income verification documentation

Name: _____ DOB: _____ Phone: _____
email_____ Employer: _____
Name: _____ DOB: _____ Phone: _____
email_____ Employer: _____
Name: _____ DOB: _____ Phone: _____
email_____ Employer: _____

<u>Children in the household:</u>

Name: _____ DOB: _____ Age: ___ Participant: Y/N
Name: _____ DOB: _____ Age: ___ Participant: Y/N
Name: _____ DOB: _____ Age: ___ Participant: Y/N
Name: _____ DOB: _____ Age: ___ Participant: Y/N
Name: _____ DOB: _____ Age: ___ Participant: Y/N

Total Number of Dependents on Tax Return: _____
Number of Adults in the home: _____ Number of Children in the home:_____

To qualify for CDBG and HOME funding please provide the documents as indicated on the following page:

For Client Use - Check List of Documents Needed for Income Verification

I filed a Federal Tax Return for last year

☐ 1040 Federal Tax forms for ALL who have filed in the household.

I am providing my 1040 forms
AND 4 months of bank statements
AND most recent 90 days of Income: Pay Stubs

I receive assistance and must provide the following:

☐ Social Services/DHR Award Letter showing proof of Food Stamps, TCA or Temporary Disability.
☐ Proof of Child Support
☐ Proof of Social Security, SSI or VA Compensation.
☐ Unemployment Compensation Letter
Proof of Foster Stipend

Total Annual Household Income $_____

OR

I did not file Federal Taxes for last year OR my household income has changed since I filed my taxes.

Documents showing income from All sources:

☐ Pay Stubs (last **90** days)
☐ **4 months bank statements**
☐ Social Services/DHR Award Letter showing proof of Food Stamps, TCA and/or Temporary Disability.
☐ Proof of Child Support
☐ Proof of Social Security, SSI or VA Compensation.
☐ Unemployment Compensation Letter
Proof of Foster Stipend

Total Annual Household Income $_____

Checking Account Balance _____
Savings Account Balance _____

If your household does not meet HUD income guidelines the program you are applying to may be aware of other funders positioned to assist you. Use this space to include any additional information or extenuating circumstances that were not included on this application. If you need more space, attach an additional sheet of paper. **I want/need assistance because:**

_____
_____
_____

I certify that the above information is true and complete to the best of my knowledge. I agree to inform (Insert Organization Name)_____ immediately of any change in my income or family. I under-stand that false or incomplete information could jeopardize my financial assistance. I/we give my/our permission to the CDBG and HOME program grant administrator to make any inquiries necessary to verify the information submitted with this application and to share necessary private data with those who need to know it or are required by Federal or State law to know it. I we understand that I/we cknowingly providing false information is against the law and is subject to prosecution.

Applicant Signature_____ Date_____

Third Party Verifications

Affidavit in Verification of Self-Employment

The affiant(s) (Name)_____of (Address)_____being first duly sworn deposes and says that_____is self-employed, said occupation being . The affiants' place of business is located at:

_____.

I sign the declaration under penalty of perjury and with full knowledge of the repercussions of willful falsification and false swearing under Indiana law.

STATEMENT OF INCOME FROM BUSINESS

Instructions:

1. Opposite GROSS INCOME insert total amount earned during the past 12 months or shorter period.
2. Add all expenses incurred in the performance of this business and subtract the total of these EXPENSES from the gross income.
3. Insert the result in the space NET INCOME.

A. GROSS INCOME: $_____period covered by GROSS income shown.

Beginning Date_____Ending Date _____

B. EXPENSES:

- Cost of goods and material $_____
- Rent (business location only) $_____
- Heat, light, water, phone, etc. (business only) $_____
- License fees $_____
- Other (specify) $_____
- Number of employees $_____
- Employee's salaries (other than self and family) $_____
- Owner's salary (self and family only) $_____

C. GROSS INCOME $_____

TOTAL EXPENSES $_____

NET INCOME $_____

D. Total amount of income taxes paid as of $_____

Federal Taxes $_____

State Taxes $_____

City Taxes $_____

TOTAL TAXES: $_____

ATTACH MOST RECENT COPY OF YOUR FEDERAL TAX RETURN.

PLEASE RETURN TO:

City of Anderson

Community Development

120 E. 8th Street RM 103, Anderson, IN 46016

The above information is correct to the best of my knowledge, and I agree to notify regarding any change in this information when it occurs.

Signature: _____ Date: _____

In witness where of, this _____ day of _____

My commission expires _____ (Notary Public) _____

Asset Verification

RE: _____ Social Security Number: _____

Applicant's Name (print)

Dear Financial Institution:

The person referenced above is a participant in a federally assisted housing program. Federal regulations require we verify all assets of program participants and their household. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____ _____

Participant's Signature Date

As of_____, the real estate property belonging to _____ has been assessed at the value of $_____. This property is located at

_____.

Street Address City State Zip

I certify this information is accurate.

_____

Signature (property valuation administrator) Name (print)

_____

Telephone Number Date

_____

Address City State Zip

PLEASE RETURN TO:

City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any department or agency of the United States or to any matter within its jurisdiction.

Banking Verification

Applicant's Name Social Security Number _____

Address _____

_____

Dear Financial Institution:

The person referenced above is a participant in a federally assisted housing program. Federal regulations require we verify all assets of program participants and their household. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____ _____

Participant's Signature Date

	Current Balance	Year-to-Date Interest Income	Date Account Opened
Savings Account:			
_____	$_____	$_____	_____
_____	$_____	$_____	_____
	Last 6 months Average Balance	Last 6 months Interest Income	Date Account Opened
Checking Account:			
_____	$_____	$_____	_____
_____	$_____	$_____	_____
Other Accounts (list)			
_____	$_____	$_____	_____
_____	$_____	$_____	_____

I certify that this information is accurate.

Signature Name (print)

Title Date

Financial Institution Telephone Number

Address City State Zip

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TBRA Programs Certification of Zero Income

I do hereby certify there is no income/money received by me from any source including, but not limited to, income from wages, public assistance, Social Security, pensions, benefits, child support, alimony, self-employment, or regular gifts.

_____	_____
(Head Signature)	(Spouse Signature)
_____	_____
(Head Print Name)	(Spouse Print Name)
_____	_____
(Other Adult Signature)	(Other Adult Signature)
_____	_____
(Other Adult Print Name)	(Other Adult Print Name)
_____	_____
(Date)	(Telephone Number)

PLEASE RETURN TO:

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Verification of Child Care Expense

RE: _____ Social Security Number _____
Participant's Name (print)

The individual referenced above is a participant in a federally assisted housing program. Federal regulations require we verify expenses paid for the care of dependent children enabling the family member to be employed or to attend school. The amounts provided must be paid out-of-pocket by the participant and may not be reimbursed from another source. Thank you for your assistance.

By signing below I authorize the release of this information and certify I am not reimbursed from any source for the amount paid.

_____
Participant's Signature Date

By signing below, I certify that I provide child care services for the above-referenced participant and receive the amount of compensation stated. Please complete all information requested.

Names of children for which child care is provided:

_____ _____
Name Age Name Age

_____ _____
Name Age Name Age

Do you receive copayments from the state or any other source for this participant's child care?
☐ Yes ☐ No

If yes, base amount $_____ Participant portion $_____ Copayment portion $_____

I receive $_____ each week for services OR I receive $_____ each month for services.

Date you began to provide child care for this participant: _____

_____ Payment is made by: ☐ Check ☐ Cash

Number of hours child care is provided each day: _____

If there are amounts received for child care during holidays, vacations, etc., please provide dates and amount received:

_____

_____

I certify this information is accurate.

Signature of Child Care Provider	Name (print)
Agency Name (if applicable)	Telephone Number
Address	City State Zip

Please return form to:

Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Child Support

RE: _____ Social Security Number: _____
Applicant's Name (print)

The person referenced above is a participant in a federally assisted housing program. Federal regulations require we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____ _____
Participant's Signature Date

Amount of child support payments provided each week: $_____

If inconsistent, list total amount in the last six months: $_____

Date child support payments began: _____ Date ended: _____

Name of children for which payments are made: _____

_____
Other assistance provided:

_____

I certify this information is accurate.

_____ _____
Signature Name (print)

_____
Address City State Zip

Title or relation to participant: _____

Agency (if applicable): _____

Telephone number _____ Date _____

Please return form to:

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Verification of Disability

RE: _____ Social Security Number: _____
Applicant's Name (print)

Dear Physician:

The person referenced above is a participant in a federally assisted housing program. We are required by federal regulations to verify the disability of program participants if they so request. Verification of a disability may qualify the family for reductions in their rent portion. The participant must meet the U.S. Department of Housing and Urban Development's (HUD's) definition of disability as provided below. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____ _____
Participant's Signature Date

HUD Definition of Disabled Person

A person is considered disabled if: (a) the following Social Security disability definition is met as described in paragraph (1), or (b) the individual has a developmental disability as described in paragraph (2). Please check as appropriate:

_____(1) Section 223 of the Social Security Act defines disability as:

"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 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."

_____(2) Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. 6001(7)] defines developmental disability in functional terms as:

"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 limitations 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 (7) economic self-sufficiency; and (e) reflects the person's need 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."

_____(3) This participant does not meet HUD's definition of disabled.

I certify that this information is accurate.

Physician's Signature | Physician's Name (print)

Medical Office

Address | City | State | Zip

Telephone Number | Date

Please return form to:

Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Informal Support

RE: _____ Social Security Number: _____
Participant's Name (print)

The above referenced person is a participant in a federally assisted housing program. Federal regulations require we verify all household income. The applicant has indicated that you provide informal support. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____
Participant's Signature Date

I certify that I provide assistance in the amount of $_____each month.

The assistance provided is for_____.

Date Assistance Began:_____ Date Assistance Ended: _____

Please list other assistance provided: _____

_____.

I certify this information to be accurate.

_____
Signature Name (print)

_____
Relationship to Participant Date

_____
Agency (if applicable) Telephone Number

_____
Address City State Zip

PLEASE RETURN TO:

Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Medical Expenses

Federal regulations require that out-of-pocket medical expenses of program participants must be verified. This information must be provided by a third party, such as a doctor or pharmacist, familiar with the actual or estimated out-of-pocket medical expenses of the participant for the next 12-month period. Expenses do not include amounts covered by insurance or reimbursed to the participant. Thank you for your assistance in providing this information.

I hereby authorize the release of this information.

Participant Name	Social Security Number
Signature of Participant	Date

MEDICAL EXPENSES

Description of Expense	Total Amount Owed	Monthly Amount Paid by Participant Out-of-Pocket	Total Amount Paid by Participant in Last 12 Months Out-of-Pocket

PHARMACEUTICAL EXPENSES

Type of Drug	How Often Purchased by Participant Monthly/Annually	Amount Paid by Participant Out-of-Pocket	Total Amount Paid by Participant in Last 12 Months Out-of-Pocket

The information provided above by:

Name (print) Date

Signature Title

Phone Number Name of Business/Office

Address City State Zip

Verification of Public Assistance and Job Training Assistance

Participant: _____ Social Security Number:_____-____-_____

Address:_____

Dear Social Service Provider: The above-mentioned person is a participant in a federally assisted housing program. We are required by federal regulations to verify the income of program participants and their household members. Please complete all of the information below. We do not include food stamps as income, but we must have food stamp, medical card, and Jobs Training, or similar program, information to process and track Family Self-Sufficiency Program participants. Thank you for your assistance.

I. Participant Authorization

By signing below, I, the participant, do hereby authorize the release of this information.

_____

Participant's Signature Date

II. Benefits Received

	Amount	Date Began	Date Ended	Year–to-Date Amount
K-TAP benefits received monthly:	$_____	_____	_____	_____
Food stamps received monthly:	$_____	_____	_____	_____
Child support received monthly:	$_____	_____	_____	_____

Medical card:_____YES_____NO

III. Training and Other Income

Work Experience/Jobs Training/or similar program:_____YES_____NO

Name of Program: _____

Date training employment began:_____ended (or will end): _____

If in Jobs Training Program, amount of original K-TAP benefits family qualified to receive (disregarding wage income): $_____Other income in household: _YES_____NO

Please list other income amounts and those receiving:

_____

Please list all household members: _____ _____

_____ _____ _____

_____ _____ _____

Official Completion of Information

By signing below, I,_____, certify that this information is accurate to the best of my knowledge.

_____ _____ _____

Signature Date Title

_____ _____ _____

Agency Agency Telephone Number

_____

Agency Address

PLEASE RETURN TO:

City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Scholarships, Grants or Work-Study

To Whom It May Concern: Date: _____

We are required by government regulations to verify the income of all Section 8 applicants and participating families. Please provide the total amount the student receives for grants, scholarships or work-study for one full year. Thank you for your cooperation. Please complete sections A, or B and C.

Name of Student: _____ SS No.: _____

I agree this information is needed to verify my income for assistance under the Section 8 Program. Although this information is considered confidential, I hereby authorize and request the information regarding my income be furnished to Anderson Housing Authority.

_____

Signature of Applicant

Section A: Type of grant, scholarship or work-study: _____

Total annual amount of grant, scholarship or work-study: $_____*

*This amount is for one: (check one) Year_____Semester_____Quarter_____Other _____

Is the student currently enrolled on a full-time basis? o Yes o No

Amount of actual grant, scholarship or work-study allocated for the following items:

Tuition/Fees	$_____
Books/Supplies	$_____
Transportation	$_____
Room/Board (on or off campus)	$_____
Other (List_____)	$_____
Total	$_____(must equal total grant or scholarship)

Section B: (Complete this section only if the amounts of specific allocations were not provided in Section A.) What was the total financial need based upon?

EXPENSES:

Tuition/Fees $_____ Other $_____

Books/Supplies $_____ List _____

Living Expenses $_____

Total Financial Need $_____

Section C: Form Completed By:

Signature: _____

Title: _____

School: _____

Date: _____

Telephone Number: _____

Address: _____

PLEASE RETURN TO:

Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

Verification of Social Security

RE: _____ Social Security Number: _____
Applicant's Name (print)

The person referenced above is a participant in a federally assisted housing program. Federal regulations require we verify the income of program participants. Please complete all the information below. Thank you for your assistance.

By signing below I authorize the Social Security Administration to release my benefit information.

_____
Participant's Signature Date

Benefit Amount: Type of Benefit (check):

Gross Social Security benefit monthly $_____ Retirement _____

Gross Supplemental Security Income Monthly $_____ Participant Disability _____

Amount deducted for Medicare $_____ Widow(er) _____

Date benefits began: _____ Date ended: _____ Children _____

Date monthly distributions began: _____

Was a lump sum paid? ☐ Yes ☐ No If yes, please list amount $_____

Status of Application: ☐ Claim is pending ☐ No record ☐ Other: _____

I certify that this information is accurate.

_____
Signature Name (print)

_____
Title Date

_____
Agency Telephone Number

_____
Address City State Zip

Please return form to:

Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Student Status

RE: _____ Social Security Number: _____
Applicant's Name (print)

Dear Educational Institution:

The person referenced above is a participant in a federally assisted housing program. Federal regulations require we verify the full-time student status of persons over the age of 18. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____ _____
Participant's Signature Date

The participant referenced above is a student at this institution and is enrolled:

Full Time ○ Part Time ○ Not

Enrolled Expected date of completion: _____

Approximate number of hours acquired in school: _____

Address of student: _____

I certify that this information is accurate.

_____ _____
Signature Name (print)

_____ _____
Institution Date

_____
Telephone Number

_____
Address City State Zip

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Anderson City of Anderson Community Development Department 120 E 8th Street RM 103, Anderson, IN 46016

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Verification of Wages

RE: _____ Social Security Number: _____
Applicant's Name (print)

Dear Employer:

The person listed above is a participant in a federally assisted housing program. We are required by federal regulations to verify the income of all program participants. Please complete all of the information below. Thank you for your assistance.

By signing below, I authorize the release of this information.

_____
Participant Signature Date

PLEASE ATTACH A COPY OF CURRENT PAYCHECK STUB

Date employment began: _____

Date employment ended: _____

Number of hours worked per week: _____

If number of hours is inconsistent, provide average: _____

Hourly wages: $_____ or Annual gross salary: $_____

Gross year-to-date earnings: $_____ As of what date: _____

Number of weeks employed each year: _____

Amount of tips, commission, other: year $_____ week $_____ month $_____

Employee's title, position or type of work: _____

Expected change in pay: $_____ Effective date: _____

Does the employee receive vacation/sick pay: oYes oNo

_____
Signature Print Name

_____
Company Date

_____
Address City State Zip

(_) _____
Telephone Number

Please Return To:

City of Anderson, Community Development Department
120 E. 8th Street RM 103,
Anderson, IN 46016

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Commonly Asked Questions

Income Calculations

If someone is paid on the 1st and 15th of the month, which calculation would be used?

- Semi-monthly.

If someone is paid every two weeks, which calculation would be used?

- Bi-weekly.

To convert income to annual amounts, multiply:

- Monthly Income x 12
- Weekly Income x 52
- Bi-Weekly x 26
- Semi-Monthly x 24
- Hourly full-time x 2080

What income is counted for a person 18 years of age or older who is not the head or spouse?

- If the person is a full-time student (is enrolled in 12 credit hours or more), count earned income of $480;
- If the person is a part-time student (is enrolled in less than 12 credit hours), count all of their income; and
- If the person is not a student, count all of their income.

When calculating employment income, is gross income (before taxes) or net income (after taxes) used?

- Gross income.

When an individual receives Social Security benefits, is the amount with or without Medicare added in?

- The amount should have Medicare added in when computing Annual Income. The Medicare is used as a Medical Allowance.

What is the income calculation formula when the family's total assets are less than $5,000?

- Use Actual Income from Assets.

What is the income calculation formula when the family's total assets are greater than $5,000?

- Use the greater of Actual Income or Imputed Income.

How is imputed income from assets calculated?

- HUD-approved passbook rate x total cash value of assets. Use the passbook calculation only when assets exceed $5,000.

What proof is required for families who declare a family member permanently absent?

- This is at the Housing Agency's discretion. A policy should be developed and put in writing.

If a person is temporarily absent, what income is counted?

- All income of a temporarily absent household member is counted.

How do you treat income received from persons outside the household?

- Count regular, not sporadic, contributions as income. This would be income received every month from a friend or family member to pay bills. This is considered informal support and should be verified through 3rd party verification.

Additional Resources

HUD Fair Market Rents

Available on the U.S. Department of Housing and Urban Development (HUD) User Website, under Data Sets, Fair Market Rents

HOME Income Limits (See Included 2018 HOME Income Limits)

Available on the HUD Website under Program Offices, Community and Development Planning, HOME Program, Income Limits

Asset Inclusions

- Savings account – current balance.
- Checking account – average monthly balance for prior 6 months.
- Stocks and bonds.
- Savings Certificates, money market funds, other investments.
- Equity in real property – must get to Cash Value.
- Trusts available to household – if unavailable and irrevocable, don't count.
- IRA, Keogh, retirement accounts.

- Company retirement pensions.
- Assets that allow unrestricted access (or savings accounts) – may be owned by more than one person.
- Lump sum receipts such as inheritances, capital gains, lottery winnings, cash from sale of assets, insurance settlements, Social security and SSI lump sums.
- Personal property held as an investment – gems, jewelry, coin collections, and antique cars.
- Cash value of life insurance policies – cash surrender value – ordinary, whole universal (not term).
- Imputed assets – assets disposed of for less than fair value within prior two years. Exceptions to this would be foreclosure, bankruptcy and separations/divorce where court determines value.

Asset Exclusions

- Personal property – car, clothes, etc.
- Assets not accessible by the family – irrevocable trusts, for example.
- Assets that are part of a business. For example, Avon products pre-purchased with intent to sell.
- Interest in Indian trust lands.

2021 Community Development HOME Income Limits

Effective 6/01/2021

City of Anderson, Indiana

Median Household Income - $ 37,038 (2019 Dollars U.S. Census)

https://www.census.gov/quickfacts/fact/table/andersoncityindiana/PST045216

	1 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON	6 PERSON	7 PERSON	8 PERSON
30% Extremely Low-Income	14050	16050	18050	20050	27200	23000	24900	26500
Very Low Income	23400	26750	30100	33400	36100	38750	41450	44100
60 % Median	28080	32100	36120	40080	43320	46500	49740	52950
Low Income	37450	42800	48150	53450	57750	62050	66300	70600

Limits for a household with more than 8 members are calculated according to the following methodology:

(A) Subtract 8 from # in household
(B) Multiply (A) by 8
(C) Add 132 to (B)
(D) Multiply (C) by 4 person limit
(E) Divide (D) by 100
(F) Round (E) to nearest $50

- very low-income" is defined as 50 percent of the median family income for the area, subject to specified adjustments for areas with unusually high or low incomes;
- "low-income" is defined as 80 percent of the median family income for the area, subject to adjustments for areas with unusually high or low incomes or housing costs;

The above income guidelines have been established by the United States Department of Housing and Urban Development (HUD) for Entitlement Cities in accordance with Section 3(b) (2) of the United States Housing Act of 1937, as amended. The City of Anderson has adopted the "low-income" limits as guidelines for its housing programs.

*****The HOME Income limits change annually. Please contact the City of Anderson Community Development Department to obtain the most current income guidelines, 765.648.6096 or lkelley@cityofanderson.com.**

https://www.hudexchange.info/programs/home/home-income-limits/

Anderson, IN

2021 HUD Metro 10

Program	Efficiency	1BR	2 BR	3 BR	4 BR	5 BR	6 BR
LOW HOME RENT LIMIT	558	619	752	868	968	1069	1169
HIGH HOME RENT LIMIT	558	619	804	1038	1104	1270	1413
FAIR MARKET RENT	558	619	804	1038	1104	1270	1435
50% RENT LIMIT	585	626	752	868	968	1069	1169
65% RENT LIMIT	740	794	956	1095	1201	1307	1413

https://www.hudexchange.info/programs/home/home-rent-limits/

Per 24 CFR Part 92.252, HUD provides the following maximum HOME rent limits. The maximum HOME rents are the lesser of:

The fair market rent for existing housing for comparable units in the area as established by HUD under 24 CFR 888.111; or

A rent that does not exceed 30 percent of the adjusted income of a family whose annual income equals 65 percent of the median income for the area, as determined by HUD, with adjustments for number of bedrooms in the unit. The HOME rent limits provided by HUD will include average occupancy per unit and adjusted income assumptions.

In rental projects with five or more HOME-assisted rental units, twenty (20) percent of the HOME-assisted units must be occupied by very low-income families and meet one of following rent requirements:

The rent does not exceed 30 percent of the annual income of a family whose income equals 50 percent of the median income for the area, as determined by HUD, with adjustments for smaller and larger families. HUD provides the HOME rent limits which include average occupancy per unit and adjusted income assumptions. However, if the rent determined under this paragraph is higher than the applicable rent under 24 CFR 92.252(a), then the maximum rent for units under this paragraph is that calculated under 24 CFR 92.252(a).

The rent does not exceed 30 percent of the family's adjusted income. If the unit receives Federal or State project-based rental subsidy and the very low-income family pays as a contribution toward rent not more than 30 percent of the family's adjusted income, then the maximum rent (i.e., tenant contribution plus project-based rental subsidy) is the rent allowable under the Federal or State project-based rental subsidy program.

Fair Market Rents are established by HUD each year for the Section 8 Program. For more information about the annual calculation of Fair Market Rents, visit HUDUSER.ORG, the website for HUD's Office of Policy Development and Research.

The FMRs for unit sizes larger than 4 bedroom are calculated by adding 15 percent to the 4 bedroom FMR for each extra bedroom. For example, the FMR for a 5 bedroom unit is 1.15 times the 4 bedroom FMR, and the FMR for a 6 bedroom unit is 1.30 times the 4 bedroom FMR, and so on...

5 BR = 1.15 x 4 BR FMR

6 BR = 1.30 x 4 BR FMR

7 BR = 1.45 x 4 BR FMR

8 BR = 1.60 x 4 BR FMR

9 BR = 1.75 x 4 BR FMR

10 BR = 1.90 x 4 BR FMR

11 BR = 2.05 x 4 BR FMR

12 BR = 2.20 x 4 BR FMR