2026 W. Main Street
Springfield, Ohio 45504.
www. smhaohio.org

P: 937.325.7331
F: 937.325.3657
spgfldhousing@smhaohio.org

Springfield Metropolitan Housing Authority

Housing Choice Voucher (HCV)/Section 8 Housing Pre-Application

INSTRUCTIONS: Pre-Applications **must be completed in full with ALL forms signed and dated.** All Pre-Applications **will be processed based on time & date received at Springfield Metropolitan Housing Authority**. **There will be NO EXCEPTIONS.**

1) YOUR PRE-APPLICATION WILL NOT BE ACCEPTED WITHOUT THE FOLLOWING:

- ✓ **Copy of Valid Driver's License, State I.D. or Valid Passport for ALL Adults.**
- ✓ **Copy of Social Security Card for ALL Occupants.**
- ✓ **Copy of State Certified Birth Certificates or Valid Passport for ALL Occupants.**
- ✓ **Complete names, addresses and phones #'s of all reported sources of income.**

2) YOU WILL BE CONTACTED IN WRITING AND BY PHONE ONCE WE GET CLOSE TO YOUR NAME ON THE LIST.

3) YOU WILL NOT HEAR FROM US BEFOREHAND. DO NOT CALL.

4) YOU ARE RESPONSIBLE FOR NOTIFYING SMHA OF ANY ADDRESS AND/OR CONTACT PHONE NUMBER CHANGES.

5) IF YOU DO NOT RESPOND TO OUR LETTER WITHIN 14 DAYS, AND WE CANNOT REACH YOU, YOU WILL BE PERMENANTLY REMOVED FROM THE LIST.

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All sections must be completed - Please Print

First__________________ Middle:_____________ Last Name:_________________
Social Security Number:______________________________

Address ____ Apt. # __________

City_______________________________ State ___ Zip Code _________

Home Phone: (_____)_________________ Other Phone: (_____)_________________

E-Mail Address: ____

Preferences (check All that Apply)

LEASE IN PLACE ☐

(The current property owner or owner's authorized representative must certify that said applicant household is a current tenant who has resided in the unit for a minimum of three months in either Clark or Champaign County and that the owner is willing to enter into a Section 8 Housing Assistance Payments (HAP) contract for this tenant and unit for a period of not less than 12 months. If the household is determined eligible, the rental unit must meet Section 8 Program requirements in order to enter into a HAP contract. If this box is checked please complete lease in place form attached.

VETERANS ☐

(An applicant who can document that they are: 1. a veteran with service-connected disability; 2. a family of a deceased veteran whose death was service-connected; 3. Or other veteran that meets the definition of SMHA's administrative plan.)

RENT BURDENED 40% OF INCOME ☐

(An applicant who can document that they are paying more than 40% of their monthly gross family adjusted income (adjustments for dependent allowance, medical expenses, etc.) toward monthly housing costs (rent and utilities)).

HOMELESS ☐

(Applicant must be currently homeless and must be able to provide third party documentation of their homelessness)

ELDERLY ☐

(An applicant or spouse who is sixty-two (62) years of age or older.)

EMERGENCY CONTACT: Person we can contact if unable to reach you

Name ___________________________ E-Mail________________________________

Address ________________________ Phone Number (_____)___________________
City ____________________________ State ____________________ Zip Code ________

Please identify any special housing needs your household may have.

____

____

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HOUSEHOLD MEMBERS

Complete information below for all persons who will live in your household while you are on the program. You must use the legal name for each member as it appears on their Social Security Administration record. All adult members of the household must sign below certifying that the information about them is true and accurate.

Full Name	Relationship to You	Date of Birth	Age	U.S. Citizen? Yes / No	Sex	Social Security Number	Race
1.	Self (Head)						
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

1. Do you expect any change in the number of people in your household? ☐ Yes ☐ No
2. If you answered yes #1, please explain: ____

____

____

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INCOME

EMPLOYMENT INCOME: List all full and part-time employment for all household members 18 and older. Include earnings from self- employment.

Household Member's Name	Employer	Address (City, State, Zip Code)	Phone #	Job Title	Monthly Earnings
					$
					$
					$

OTHER SOURCES OF INCOME: List all other income for all household members, including AFDC (TANF), Social Security, SSI, Pensions,VA, Military Pay, Alimony, Child Support, Unemployment Benefits, Contributions from Outside Sources, Any Other Income:

Household Member's Name	Source of Income	Monthly Amount	Case Number
		$	
		$	
		$	

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ASSETS

Please complete all blanks. If not applicable, put none.

Type of Account	Bank Name	Account #	Current Balance	Interest % Rate
Checking			$	%
Savings			$	%
Pay Card			$	%
Annuities/Life Insurance			$	%
Certificate of Deposit			$	%
Stocks			$	%
Bonds			$	%
US Savings Bonds			$	%

Has any household member ever owned real estate? □ Yes □ No

If yes, when?_____________

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MONTHLY HOUSEHOLD EXPENSES

How much do you pay each month for the following? Please complete all blanks. If not applicable, put none.

Rent	$	Disability Expenses	$
Gas	$	Child Care	$
Electric	$	Household Supplies	$
Water	$	Cable	$
Trash	$	Yard Maintenance	$
Telephone	$	Car Payments	$
Cell Phone	$	Gasoline	$
Food	$	Public Transportation	$
Medical	$	Personal Loan/Credit Card	$
Clothing	$	Internet Access	$
Insurance	$	Other	$

If no income, who helps you with these expenses?

Comments:____
____
____
____

CHILD CARE EXPENSES

Childcare is provided for (names of children) ____

____

Childcare is paid to: ______________________________________ (Name of provider)

Address ________________________ City ___________St _____ Zip ______________

Phone _________________________ Fax _____________________

in the amount of: $ _________________ per week / biweekly / monthly (please circle one)

and enables ___________________ (name) to work, or _______________________ (name) to attend school.

Amount reimbursed $ _____________ per week / biweekly, monthly (please circle one)

Name of Person/Agency who pays for childcare: ____

MEDICAL AND UNUSUAL EXPENSES

Complete only if the HEAD of household is disabled or 62 years old or older

	Yes		No			
Do you have Medicare benefits?	Yes	☐	No	☐		
Do you have other Health Insurance?	Yes	☐	No	☐	Amount of premium(s)	$ ______ Per ____
Do you make payments on medical bills?	Yes	☐	No	☐	Amount of payment(s)	$ ______ Per ____
Do you pay for prescription medicines?	Yes	☐	No	☐	Amount paid for medicine(s)	$ ______ Per ____

Are there any changes anticipated in health care related expenses in the next 12 months not covered by insurance?

Yes ☐ No ☐ If yes, explain: ____

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STUDENTS – List all household members 17 years old or older who are attending school or other training program.

Household Member's Name	Name of School or Training Program	Address of School or Training Program	Full Time or Part Time

OTHER INFORMATION

Is the owner of the unit you are living in related to you or any member of your household?
Yes ☐ No ☐

Have you or any family member living with you ever been charged with drug-related or violent criminal activity? Yes ☐ No ☐

Have you or any family member living with you ever been evicted from federally assisted housing for drug-related or violent criminal activity? Yes ☐ No ☐

Are you or any family member/ household member subject to a lifetime sex offender registration requirement in any state? Yes ☐ No ☐

If yes on any of above, explain.

____
____
____
____

Do you or any household member owe a balance to Springfield Metropolitan Housing Authority or any other subsidized housing program? Yes ☐ No ☐

If yes, please stated what Housing Authority and approximate date.

____

Have you or any other household member ever participated in any of the following programs before?

HCV/Section 8 Yes ☐ No ☐

Public Housing Yes ☐ No ☐

Hope VI Yes ☐ No ☐

Other Subsidized Programs Yes ☐ No ☐

If Yes to any of above: Where? ______________________ Dates?_____________________

Does any member of your household have elevated blood-lead level? Yes ☐ No ☐

Are all members of your household U.S. Citizens or legal residents? Yes ☐ No ☐

Are you or any family member a current or former member of the military? Yes ☐ No ☐

If Yes, which member and dates of service? __ From:_____ To: ___________

Have you or other family member been a victim of domestic violence? Yes ☐ No ☐

If Yes, which member and date(s) ______________________

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CERTIFICATION

I/We certify that the information provided to the Springfield Metropolitan Housing Authority on this application as well as on household composition, income, net family assets, allowances and deductions is accurate and complete to the best of my/our knowledge. I/We understand that false statements or information are punishable under State and Federal law under Section 1001 of Title 18 of the U.S. Code which provides penalties up to $10,000 or imprisonment up to five (5) years or both. I/we also understand that false statements or information are grounds for me being charged retroactive rent and/or being denied or terminated from the housing choice voucher Section 8 program.

____ _______/______/__________

Signature of Head of Household **Date**

____ _______/______/__________

Signature of Co-Head of Household or Spouse **Date**

____ _______/______/__________

Signature of Other Adult Family Member **Date**

____ _______/______/__________

Signature of Other Adult Family Member **Date**