Social Security Administration will not provide verification of Social Security, Supplemental Security Income (SSI) and Retirement Survivors Disability Insurance (RSDI) benefits. You must provide a <u>current</u> copy of your benefits statement to our office.

If you have any questions, please call our Montevideo office at 320-269-6640 and dial ext. 217 for Amber, ext. 226 for Charlie, or ext. 227 for Jessica.

<u>Translations provided by Google Translate; Van Binsbergen and Associates, Inc cannot verify accuracy.</u>

<u>English</u>

This is an important document. If you cannot read English, you should have it translated.

<u>Spanish</u>

Este es un documento importante. Si usted no puede leer inglés, tendrá que haberlo traducido.

<u>Somali</u>

Tani waa dokumenti muhiim ah. Haddii aad waxba ma aan akhriyi karo Ingiriisi, waa in aad u tarjumay.

<u>Loa</u>

ນີ້ເປັນເອກະສານທີ່ສໍາຄັນ. ຖ້າຫາກວ່າທ່ານບໍ່ສາມາດອ່ານພາສາອັງກິດ, ທ່ານຄວນຈະມີມັນແປ.

<u>Vietnamese</u>

Đây là một tài liệu quan trọng. Nếu bạn không thể đọc được tiếng Anh, bạn cần phải có nó dịch.

<u>Hmong</u>

Qhov no yog ib qho tseem ceeb daim ntawv no. Yog hais tias koj nyeem tsis tau ntawv Askiv, koj yuav tsum tau kom muab txhais.

<u>Khmer</u>

នេះគឺជាឯកសារសំខាន់។ ប្រសិនបើអ្នកមិនអាចអានភាសាអង់គ្លេសបានអ្នកគួរតែវាបានបកប្រែ។

It is time to complete your recertification for your household. Please keep in mind, our office requires time to process your recertification and your prompt response is necessitated.

If you have any questions, please contact our office at 320-269-6640, ext. 217 for Amber, ext. 226 for Charlie, and ext. 227 for Jessica.

Return completed, signed and dated paperwork to:	**OFFICE USE ONLY**	
Van Binsbergen & Associates	Date Received	
540 South First Street **Fax: 320-269-7789**		
Montevideo, MN 56265 **Email: office@vanbllc.com**	Time Received	

PROPERTY NAME			
TENANT NAME			
ADDRESS			
CITY		STATE	ZIP
PHONE		CELL	
EMAIL			

Social Security will no longer furnish verification of Social Security, Supplemental Security Income (SSI) or Retirement, Survivors, Disability Income (RSDI) benefits. If you have not sent a copy of your current benefit statement or award letter to our office, please return a copy when returning your recertification paperwork. If you do not have a copy of your current letter, you can contact your local Social Security office in Marshall.

ADDRESS: 507 Jewett St
Marshall, MN 56258

PHONE: 800-772-1213 OR 507-532-2850
TTY : 800-325-0778

You can also visit the Social Security website, create an account, and get your new letter online.

WEBSITE: http://www.socialsecurity.gov/

Unemployment Benefits verification must be supplied by the resident in the form of a printout from the Minnesota Unemployment Insurance website located at http://www.uimn.org/uimn/. These printouts must show resident's name, benefit amounts, dates received, and date printed. If you are receiving or will be receiving benefits, you should have the information needed to log into your account.

IMPORTANT: The bottom section on page 3 of the recertification packet must be completed. This section provides our office with the contact information for any questions answered "yes" from questions 1-42. This section starts with the gray shaded box and is clearly labeled "DO NOT LEAVE THIS SECTION BLANK."

If you are elderly or disabled, please provide the name and contact information for your current medical provider.

Physician's Name	
Clinic/Hospital Name	
Address	
City, State, Zip Code	
Phone Number	

Your timely response during the recertification process in sincerely appreciated!

Equal Housing Opportunity

Household Questionnaire

Certification Effective Date:	Household certifying for the following program(s):	Date and Time Rec'd: _____
☐ Move-in _____	☐ Section 8 ☐ NHTF	Rent Amount: $_____
☐ Initial Cert _____	☐ Housing Tax Credit	
☐ Recertification _____	☐ HOME	
☐ Add a Member _____	☐ Section 236	
	☐ Other _____	

Property Name_____ Bldg/Unit #_____

Household Composition

Applicants/residents, complete this application in your own handwriting. List all persons who will be living in the unit. Give the relationship of each family member to the head of household. If this eligibility application is being completed by an applicant who is applying for occupancy with an existing household, only include the information for the new applicant. **Each household member age 18 years or older and under age 18 if head, spouse, or co-head of household must disclose income and assets and sign and date this application.**

	Household Member's Name	Relationship	Date of Birth	Has/Will this person be a student* during this and/or the upcoming calendar year? YES/NO	Social Security Number
1		HEAD			
2					
3					
4					
5					
6					
7					
8					

* Include public and private elementary, junior & senior high, college, university, technical, trade, and mechanical schools. Do not include on-the-job training courses.

Household Income

List current and anticipated income for the twelve-month period beginning on the anticipated move-in date or effective date of recertification. **Include all full time, part time or seasonal income even if completing this application in the off-season**.

DOES ANY MEMBER RECEIVE OR EXPECT TO RECEIVE

(Check **YES or NO** to each item, as applicable, and include gross monthly amount. List sources on page 2.):

YES Amount	NO		Gross Monthly
		1. Wages, salaries (include overtime, tips, bonuses, commissions, etc.)	$
		2. Does any member work for someone who pays them in cash, is self-employed or does "app" or "gig" work.	$
		3. Regular pay for a member of the armed forces	$
		4. Public Assistance (MFIP, GA, MSA) **Benefits are received by (circle one)** direct deposit check cash card	$
		5. Worker's compensation	$
		6. Unemployment benefits or severance pay	$
		7. Student financial assistance (public or private, not including student loans)	$
		8. Child support (check yes if you have a court order, even if you are not receiving the full amount awarded) .	$
		9. Alimony/Spousal Maintenance	$
		10. Social Security income (including unearned income of minor children)	$
		11. Disability benefits including social security disability	$
		12. Regular payments from pensions (PERA, railroad, etc.)	$
		13. Regular payments from retirement benefits	$
		14. Death Benefits	$
		15. Regular payments from annuities or life insurance dividends	$
		16. Regular payments from inheritance, insurance settlement, lottery winnings, etc.	$
		17. Net income from rental property	$
		18. Regular cash and non-cash contributions, assistance with paying bills (including utilities), or gifts from companies, agencies or individuals not living in the unit (not including groceries).	$
		19. Are any changes to income expected within the next 12 months due to a raise, bonus or other reason?	$
		20. Other (list) _____	$

Household Assets

YES	NO	DOES ANY HOUSEHOLD MEMBER (INCLUDING CHILDREN) HAVE MONEY HELD IN:	Current Balance
		21. Checking Accounts . . . . . (6 month average balance)	$
		22. Savings Accounts	$
		23. Cash cards used to receive government benefits or other income	$
		24. Online donation accounts such as GoFundMe, Kickstarter, Fundly, local bank, etc.	$
		25. US Savings Bonds	$
		26. Trusts*	$
		27. Securities	$
		28. Whole or Universal Life Insurance Policy (do not include term life insurance)	$
		29. 401K*	$
		30. IRA/KEOGH Accounts	$
		31. Certificates of Deposit	$
		32. Pension/Retirement/Annuity.	$
		33. Money Market or Mutual Funds	$
		34. Treasury Bills	$
		35. Stocks	$
		36. Lump Sum Payment (i.e., inheritance, insurance settlement, lottery winnings, capital gains)	$
		37. Are any accounts held jointly with someone not in the unit? Which account and with whom?	
		38. Other (include cash on hand)_____	$

*Include Trusts, 401K, etc., only if the accounts are accessible to the household prior to termination of employment, retirement, or death. If you are unsure, list the account and it will be verified.

YES	NO		Value
		39. Do you now own a home or other real estate?	$
		If yes, list address(es):	
		40. Do you receive payments for a home you sold by contract for deed?	$
		41. Do you have any coin collections, antique cars, gems/jewelry, stamps or any other items . . . . . held as an investment (wedding rings and personal jewelry do not count)?	$
		42. Are any assets held jointly with another person? List person and asset(s).	
		Enter combined cash value of all household assets	$

DO NOT LEAVE THIS SECTION BLANK.

From **1-42, income and assets** above, provide contact information for all "YES" checked items. All information must be verified. (If a household member has more than one source of income and/or asset, use a separate line for each source. Use additional sheets, if necessary.)

Item Number	HH Member	Name and mailing address of income or asset source and educational institution for household members age 18 or older.	Contact name and phone/fax/email

Please attach documentation available to verify income (e.g., divorce/settlement papers, tax returns, social security benefit award letter, etc.).

DAYCARE:

Do you have child care expenses for child/ren under age 13 because you work, are actively seeking employment or attending school? If yes, list name and address of provider: _____

Is any portion paid by another person or agency? If yes, list contact information of agency: _____

COMPLETE THIS SECTION **ONLY** IF HEAD OF HOUSEHOLD, CO-HEAD, OR SPOUSE ARE AT LEAST 62 YEARS OR OLDER OR HANDICAPPED OR DISABLED.

EXPENSE	NAME	YES	NO	AMOUNT	CONTACT INFORMATION
MEDICARE PART A					Name: Phone Number:
MEDICARE PART B					Name: Phone Number:
MEDICARE PART C					Name: Phone Number:
HEALTH INSURANCE Provide copy of monthly premium					Name: Phone Number:
OTHER MEDICAL HEALTH INSURANCE					Name: Phone Number:
MEDICAL ASSISTANCE SPENDOWN					Name: Phone Number:
OPTOMOLOGIST (Eyes)					Name: Phone Number:
EYEGLASSES/CONTACTS					Name: Phone Number:
AUDIOLOGIST (Hearing)					Name: Phone Number:
HEARING AIDS/BATTERIES					Name: Phone Number:
DENTAL & DENTAL EXPENSES					Name: Phone Number:
PRESCRIPTION MEDICATIONS					Name: Phone Number:
NON-PRESCRIPTION MEDS -Must be verified w/physician -Resident must provide receipts					Name: Phone Number:
HOME HEALTH CARE					Name: Phone Number:
MEDICAL EQUPMENT COSTS					Name: Phone Number:
MEDICAL RELATED TRAVEL -Number of visits must be verified w/physician					Name: Phone Number:

PLEASE ATTACH ADDITIONAL SHEET IF MORE SPACE IS NEEDED.

PLEASE UPDATE YOUR EMERGENCY CONTACT:

NAME			
ADDRESS			
CITY		STATE:	ZIP:
PHONE		CELL	
EMAIL		RELATIONSHIP:	

Household Questionnaire

I/We hereby certify that I/We ☐Have ☐Have not sold or given away any assets for less than Fair Market Value during the two year (24 month) period preceding the date of this questionnaire. Any assets sold or disposed of for less than Fair Market Value must be identified below:

Household Member	Asset and Estimated Market Value	Date sold/disposed	Amount Received
			$
			$

ADDITIONAL INFORMATION

The following questions pertain to every member of the household. Check either **YES or NO** in response to each question. Add an explanation below for all items checked YES.

Yes	No	
☐	☐	Will any household member, including children, live in the unit on a less than full time basis?
☐	☐	Do you anticipate any change in your household (someone moving in or out) during the next 12 months?
☐	☐	Does any adult member of the household have zero income? If yes, name(s): _____
☐	☐	Does/will the household receive rent assistance? If so, indicate from what source (Section 8, Rural Development RA, etc.).
☐	☐	Does your household have any needs that might be better served by a unit which is accessible to persons with mobility, hearing or visual impairments?

Explanation: _____

SIGNATURES

I/we certify that the foregoing information is true and complete to the best of my/our knowledge, and authorize the Landlord to make inquiries to verify the statements herein. I/we further understand that any intentional misrepresentation on this form might result in a default in the rental agreement and/or eviction of this household. If any of the aforementioned information changes, I/we agree to notify Landlord immediately.

Applicant/Resident Signature _____ Date _____

Applicant/Resident Signature _____ Date _____

Applicant/Resident Signature _____ Date _____

Applicant/Resident Signature _____ Date _____

Head of household email address: _____ Phone: _____

This applicant/resident required assistance in completing the Household Questionnaire due to: _____

Assistance was provided by: _____ **Date:** _____

ANNUAL STUDENT CERTIFICATION

Effective Date: _____
Move-in Date: _____
(MM/DD/YYYY)

This Annual Student Certification is being delivered in connection with the undersigned's application/occupancy in the following apartment:

Head of Household Name: _____ Unit Number: _____

Property Name _____ Building Address: _____

Check A, B, or C, as applicable (note that students include those attending public or private elementary schools, middle or junior high schools, senior high schools, colleges universities, technical, trade, or mechanical schools, but does not include those attending on-the-job training courses):

A. _____ Household contains at least one occupant who is not a student and has not been/will not be a student for five months or more out of the current and/or upcoming calendar year (months need not be consecutive). *If this item is checked, STOP no further information is needed. Sign and date below.*

B. _____ Household contains all students, but is qualified because the following occupant(s) _____ _____ is/are a PART TIME student(s) who have not been/will not be a full time student for five months or more of the current and/or upcoming calendar year. *Verification of part-time student status is required for at least one occupant. If this item is checked, STOP. Sign and date below. Verification of part time student status is required for at least one occupant.*

C. _____ Household contains all students who were, are, or will be FULL-TIME students for five months or more out of the current and/or upcoming calendar year (months need not be consecutive). *If this item is checked, questions 1-5, below **must be** completed:*

1.	Is at least one student receiving Temporary Assistance to Needy Families (TANF), otherwise known as Minnesota Family Investment Program (MFIP)? (provide release of information for verification purposes)	YES	NO
2.	Does at least one student participate in a program receiving assistance under the Job Training Partnership Act, Workforce Investment Act, or under other similar, federal, state or local laws? (attach verification of participation)	YES	NO
3.	Is at least one student a single-parent with child(ren) *and* this parent is not a dependent of someone else, *and* the child(ren) is/are not dependent(s) of someone other than a parent? (attach student's and if applicable, divorce/custody decree or other parent's most recent tax return)	YES	NO
4.	Are the students married and entitled to file a joint tax return? (attach marriage certificate or tax return)	YES	NO
5.	Does the household consist of at least one student who was under the care and placement responsibility of the state agency responsible for administering foster care? (provide verification of participation)	YES	NO

*Full-time student households that are income eligible and satisfy one of the above conditions are considered eligible. If C is checked and questions 1-5 are marked **NO**, or verification does not support the exception indicated, STOP the household is considered ineligible.*

Under penalties of perjury, I/we certify that the information presented in this Annual Student Certification is true and accurate to the best of my/our knowledge and belief. I/we agree to notify management immediately of any changes in this household's student status. The undersigned further understands that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of the lease agreement.

All household members age 18 or older must sign and date.

_____ Signature	_____ *(Date)*	_____ Signature	_____ *(Date)*
_____ Signature	_____ *(Date)*	_____ Signature	_____ *(Date)*

TENANT RELEASE AND CONSENT

I/We, the undersigned, hereby authorize all representatives of companies/agencies in the categories listed below to release, without liability, information regarding employment, additional forms of income, benefits, assets, and references to **Van Binsbergen & Associates, Inc.** (Owner and/or Agent), for purposes of verifying information listed on the rental application.

INFORMATION COVERED

I/We understand that previous or current information regarding my/our household may be needed. Verifications and inquiries that may be requested include, but are not limited to: personal identifiers; employment, income and assets; medical or child care allowances. I/We understand this authorization cannot be used to obtain any information which is not pertinent to eligibility as a qualified tenant.

GROUPS OR INDIVIDUALS WHO MAY BE CONTACTED

The groups or individuals who may be asked to release the above information include, but are not limited to:

Past and Present Employers	Veterans Administration	Welfare Agencies
State Unemployment Agencies	Social Security Administration	Retirement Systems
Support and Alimony Providers	Banks/Other Financial Institutions	Colleges & Universities
Medical and Child Care Providers	Previous Landlords	Public Housing Agencies

SAVE VERIFICATION CONSENT FORM

For every household member (adult or child) identified as an eligible noncitizen on the application, the signatures below provide consent to the following for the individual and/or signature of parent/guardian for household members under the age of 18:

1. The use of provided evidence/documentation to verify eligible immigration status to enable household members to receive financial assistance for housing.
2. The release of such evidence to the DHS for purposes of verification of the immigration status of the individual.

CONDITIONS

I/We agree that a photocopy of this authorization may be used for the above stated purpose(s). The original of this authorization is on file and will stay in effect for a year and one month from the date signed. I/We understand I/we have a right to review this file and correct any information that is incorrect.

SIGNATURES

_____	_____
Signature	Printed Name & Date
_____	_____
Signature	Printed Name & Date
_____	_____
Signature	Printed Name & Date
_____	_____
Signature	Printed Name & Date

29565

Verification of Deposit

Housing Assistance Agencies

WELLS FARGO

For faster processing, please complete the form on your computer before printing.

This form is for housing assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number noted below. Your completed request will be faxed to the return fax number provided on this form.

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Requests To.....1-844-879-0412
Online Instructions.....www.wellsfargo.com/biz/vod
Balance Confirmation Services.....1-540-563-7323

SECTION 1: REQUESTER INFORMATION

VANBINSBERGEN & ASSOC. INC.
Company Name

Attention

540 S 1ST ST.
Street Address

MONTEVIDEO | MN | 56265
City | State | Zip

Requester Email (optional)

320-269-6640
Requester Phone Number

320-269-7789
Return Fax Number

SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Account Number(s) (Required)

___ - ___ - ____
Customer One Social Security Number

__ / __ / 20__
Month / Day / Year

CUSTOMER AUTHORIZATION

I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.

Signature of Account Holder **Date** **Signature of Account Holder** **Date**