

Complete and Return the Original Signed Application Portion Only (pages 1 – 10)

**SWNCBC REGIONAL HOUSING DOWN PAYMENT/CLOSING COST ASSISTANCE WITH
REHABILITATION PROGRAM
APPLICATION - 20TFHO33022**

APPLICANT INFORMATION

OFFICE USE

(complete name)

(mailing address)

_____, NEBRASKA _____ (zip)

(phone number)

Application # _____ Date Recd. _____ Time _____

By mail _____ In person _____ (check one)

Delivered by _____

(signature of person accepting application)

APPLICANT ACKNOWLEDGEMENT

CERTIFICATIONS AND AUTHORIZATIONS

I/We hereby certify that by signing this application, the information stated herein is true and correct to the best of my/our knowledge. I realize that giving false information will result in disqualifying me from assistance in the Southwest Nebraska Community Betterment Corp. (SWNCBC) Regional DPA/with Rehab Program 20TFHO33022.

I/We hereby certify that we have received a copy of the Policies and Guidelines of this program, the Lead Hazard Information Pamphlet, and Radon Information Pamphlet. A personal home radon testing kit will be provided to each applicant if requested.

I/We authorize the SWNCBC to access all information required to verify the following information in order to determine eligibility for the above referenced program.

I/We authorize the SWNCBC to use before and after photos in marketing materials with no applicant names or addresses connected to the photos.

In regards to the Rehab portion, all applicants will be referred to USDA-Rural Development for funding under this program as well as any weatherization programs that may apply. I/we authorize all information within this application be forwarded to partnering agencies to be reviewed for their home repair grant programs. No applicant will be required to take a *loan* from any partnering agency as their first source as program assistance. All applicants will be encouraged to take a *grant* from any partnering agency as a source of program assistance. No relocation financial assistance will be provided you in the event you must move out of your home to complete rehabilitation work.

(applicant signature) (date)

(applicant signature) (date)

print name

print name

A. HOUSEHOLD DATA

1. Head of Household: (FAMILY MEMBER #1)

Full Name _____ Age _____

Occupation _____

Employer _____

2. Spouse/Significant Other (FAMILY MEMBER #2)

Full Name _____ Age _____

Occupation _____

Employer _____

3. Names and Ages of all other household members

Family Member #3 _____ Age _____

Family Member #4 _____ Age _____

Family Member #5 _____ Age _____

Family Member #6 _____ Age _____

4. Are any members of the Household

Handicapped or disabled? ____ yes ____ no (check one)

(If yes please explain) _____

Does your home require the removal of architectural barriers ____ yes ____ no
(please check one)

B. HOUSEHOLD INCOME AND ASSET DATA

EMPLOYMENT INCOME

PROVIDE THE PAST THREE CURRENT PAY STUBS FOR EACH WORKING FAMILY MEMBER.

PLEASE COMPLETE AND SIGN THE ATTACHED EMPLOYMENT VERIFICATONS FOR EACH EMPLOYER OF EACH WORKING MEMBER OF THE HOUSEHOLD. LEAVE THE BOTTOM PORTION OF THE AUTHORIZATION BLANK. WE WILL CONTACT YOUR EMPLOYER DIRECTLY.

1. Family Member #1 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$ _____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

2. Family Member #2 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$_____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

3. Family Member #3 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$_____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

4. Family Member #4 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$_____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

5. Family Member #5 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$_____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

6. Family Member #6 _____

Employer Name and Address _____

Amount of Gross Income from wages (before taxes)

\$_____ hourly weekly bi-weekly monthly semi-monthly yearly
(circle one above)

SOCIAL SECURITY – Do you received Social Security Benefits? ____yes ____no
(please check one)

Monthly Amount \$ _____

PROVIDE A COPY OF THE CURRENT YEAR SOCIAL SECURITY OR SOCIAL SECURITY DISABILITY STATEMENT

PENSION ____yes ____no (please check one)

Monthly Amount \$ _____ Account # _____

Name and Address _____

PROVIDE A COPY OF THE CASH BALANCE FROM THE PENSION LAN

INVESTMENTS ____yes ____no (please check one)

Source _____

Address: _____

PROVIDE A COPY OF THE CASH BALANCE OF INVESTMENTS

OTHER INCOME TO INCLUDE ALIMONY, CHILD SUPPORT, FOOD STAMPS, ETC.

____yes ____no (please check one)

Type of Income _____ Monthly Amount \$ _____

Source _____

Address _____

IF APPLICABLE, PROVIDE A COPY OF YOUR COURT ORDERED CHILD SUPPORT (DIVORCE DECREE), AS WELL AS THE HHS BENEFIT STATEMENT.

TIPS

Do you work in a job that you receive tips? ____ yes ____ no

If yes, what is the average amount of tips you receive weekly \$ _____

Employer: _____

IF APPLICABLE, PROVIDE A WRITTEN SIGNED STATEMENT INDICATING THE AVERAGE AMOUNT OF TIPS YOU RECEIVE WEEKLY.

CHECKING ACCOUNT ____yes ____no (please check one)

Balance \$ _____ Bank _____

Address _____

SAVINGS ACCOUNT ____yes ____no (please check one)

Balance \$ _____ Bank _____

Address _____

IF APPLICABLE, COMPLETE AND SIGN THE ATTACHED BANK AUTHORIZATION FOR ANY CHECKING AND SAVINGS ACCOUNTS FROM ALL BANKS. LEAVE THE BOTTOM PORTION OF THE FORM BLANK, WE WILL OBTAIN THE INFORMATION FROM YOUR BANKING INSTITUTION.

REAL ESTATE Do you currently own any real estate?

____yes ____no (please check one)

Legal Description_____

SECURITIES ____yes ____no (please check one)

Address_____

SELF EMPLOYED ____yes ____no (please check one)

IF YES, PROVIDE A COPY OF THE MOST RECENT 3 YEARS FEDERAL TAX RETURNS.

C. DWELLING DATA

ADDRESS OF PROPERTY BEING PURCHASED (IF KNOWN)

Is your home located within the municipal boundaries of the community in which you live?
____yes ____no

Is it on public water and public sewer? ____yes ____no
(please check one)

IS THE PROPERTY A SINGLE WIDE MOBILE HOME?

____yes ____no (please check one)

If the property you are purchasing is a single wide mobile home, do not continue with the application, the property is not eligible for this program.

TYPE OF DWELLING BEING PURCHASED (please check one below)

Single Family _____
Duplex Condominium _____
Mobile Home** _____
Modular Home *** _____

**mobile homes are not eligible for program funds

***modular home must bear label it was built in compliance with National Manufactured Home Construction and Safety Standards.

IF APPLICABLE PLEASE PROVIDE A PHOTO OF THE MOBULAR HOME LABEL AS NOTED ABOVE.

COPY OF HOMEOWNERS INSURANCE WITH SWNCBC AS SECONDARY LOSS PAYEE TO BE PROVIDED AT CLOSING

United States Citizen Attestation

For the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, I attest as follows:

- I am a citizen of the United States
- I am a qualified alien under the federal immigration and Nationality Act, my immigration status and alien number is _____, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

All adults living in the household, receiving benefit of this program must sign this form.

Printed name

Signature

Printed name

Signature

Printed name

Signature

Printed name

Signature

This information is being requested in accordance with reporting requirements by the Nebraska Department of Economic Development.

Racial or Ethnic Group - List how many persons in the household are in the following ethnic groups?

___ *American Indian/Alaskan* ___ *Asian/Pacific Islander* ___ *Black/African American*
___ *Hispanic/Latino* ___ *White/Caucasian* ___ *Other*

Household Gender – Please enter the number of females and number of males in the household

___ *Female* ___ *Male*

Is Applicant Female Head of Household?

Yes *No*

(check yes or no)

If you are found eligible for this program and your home is rehabilitated, you will be required to place SWNCBC as loss payee on your insurance policy with continual coverage provided for a period of ten (10) years or for the duration of the affordability period of the program.

Supporting documentation is required to be submitted with the application. Paperwork needed is marked with a check box near the left margin of the application. Applications are not considered complete without submitting the check box items.

Following review of your application, additional paperwork may be requested to complete income verification.

Complete and Return the original signed application portion only, applications can be scanned and emailed; we **cannot** accept applications that are faxed.

Southwest Nebraska Community Betterment Corp.

By mail:

PO Box 720

Grant, NE 69140 -0720

Hand delivery:

115 W. 3rd Str.

Grant, NE 69140

Southwest Nebraska Community Betterment Corp.

PO Box 720/115 W. 3rd Str.

Grant, NE 69140

(308)352-4338

EMPLOYMENT VERIFICATION - HEAD OF HOUSEHOLD

Employer _____ phone _____

Address _____ social security # _____

_____ **fax number of employer** _____

Employee Name _____
(printed name)

I hereby authorize the release of my employment information.

_____ date _____
(signature of employee)

The individual named directly above is an applicant of the SWNCBC DPA/with Rehabilitation Project that requires verification of income. The information you provide will remain confidential and will be used solely for the purpose of determining eligibility to the program. Your prompt response is greatly appreciated. **Please fax or email completed document to info below.** Thank you.

Program Administrator _____
Deb Marshall – Program Administrator
SWNCBC
PO Box 720 – Grant, NE 69140
(308)352-4338 - fax (308)352-2683 - swncbc@gpcom.net

Leave this section Blank, we will contact your employer

Employee name: _____ Job Title: _____

Presently employed: ___yes ___no (check one) If no last date of employment: _____

Current Wage/Salary \$ _____ per hourly weekly bi-weekly semi-monthly yearly
(please circle one above)

Frequency of Pay: daily weekly bi-weekly semi-monthly monthly yearly
(please circle one above)

Average number of regular hours per week: _____ Year to Date Earnings\$ _____

Average number of overtime hours per week: _____ Overtime Rate of pay \$ _____

Commissions/bonuses, tips (explain): _____

Do you anticipate any change in the employee’s rate of pay within the next 12 months? _____
If so effective date; _____

Does the employee have a Retirement plan or 401K? ___yes ___no (please check one)

If so, do they have access to the account? ___yes ___no (please check one)

If employees work is seasonal, please indicate layoff periods: _____

_____ (signature of employer) _____ (printed name of employer) _____ (date)

Southwest Nebraska Community Betterment Corp.
PO Box 720/115 W. 3rd Str.
Grant, NE 69140
(308)352-4338

EMPLOYMENT VERIFICATION – SPOUSE/HOUSEHOLD MEMBER

Employer _____ phone _____

Address _____ social security # _____

_____ **fax number of employer** _____

Employee Name _____
(printed name)

I hereby authorize the release of my employment information.

(signature of employee) date _____

The individual named directly above is an applicant of the SWNCBC DPA/with Rehabilitation Project that requires verification of income. The information you provide will remain confidential and will be used solely for the purpose of determining eligibility to the program. Your prompt response is greatly appreciated. **Please fax or email completed document to info below.** Thank you.

Program Administrator Deb Marshall – Program Administrator
SWNCBC
PO Box 720 – Grant, NE 69140
(308)352-4338 - fax (308)352-2683 - swncbc@gpcom.net

Leave this section BLANK, we will contact your employer

Employee Name: _____ Job Title: _____

Presently Employed: ___yes ___no (check one) If no last date of Employment: _____

Current Wage/Salary \$ _____ per hourly weekly bi-weekly semi-monthly yearly
(please circle one above)

Frequency of Pay: daily weekly bi-weekly semi-monthly monthly yearly
(please circle one above)

Average number of regular hours per week: _____ Year to Date Earnings\$ _____

Average number of overtime hours per week: _____ Overtime Rate of Pay \$ _____

Commissions/bonuses, tips (explain): _____

Do you anticipate any change in the employee’s rate of pay within the next 12 months? _____
If so effective date; _____

Does the employee have a Retirement plan or 401K? ___yes ___no (please check one)

If so, do they have access to the account? ___yes ___no (please check one)

If employees work is seasonal, please indicate layoff periods: _____

(signature of employer) (printed name of employer) (date)

Southwest Nebraska Community Betterment Corp.
PO Box 720/115 W. 3rd Str.
Grant, NE 69140
(308)352-4338

BANK VERIFICATION

Bank _____ Phone _____

Address _____ Social Security # _____

_____ **Fax Number of Bank** _____

Account Holder Name _____
(printed name(s))

I hereby authorize the release of my banking information.

(signature) Date _____

(signature)

The individual(s) named directly above are applicant(s) of the SWNCBC DPA/with Rehabilitation Project that requires verification of assets. The information you provide will remain confidential and will be used solely for the purpose of determining eligibility to the program. Your prompt response is greatly appreciated. **Please fax or email completed document to info below.** Thank you.

Program Administrator Deb Marshall – Program Administrator
SWNCBC
PO Box 720 – Grant, NE 69140
(308)352-4338 - fax (308)352-2683 - swncbc@gpcom.net

Leave this section BLANK we will contact your financial institution

SAVINGS ACCOUNT: SAVINGS ACCOUNT:
Account# _____ Account # _____

Current Balance _____ Current Balance _____

CHECKING ACCOUNT: CHECKING ACCOUNT:

Account # _____ Account# _____

6 month avg balance _____ 6 month avg balance _____

Please list other assets accounts below to include CD's Money Markets etc.

Account Type: _____ Bal \$ _____ Int Rate _____ Cash Value \$ _____

Account Type: _____ Bal \$ _____ Int Rate _____ Cash Value \$ _____

(signature) (printed name and title) (date)

(bank name) (address)

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