PROJECT: **HOMEOWNER SURVEY FOR OPTIONAL RELOCATION ASSISTANCE**

Name:	Current Address:
Unit #:	Telephone No:
Number of Bedrooms: Number of Rooms:	Mortgage **Yes**☐ **No**☐ **N/A**☐ Current mortgage: $ /month, lease provided? Utilities: $ /month, bills or receipts provided? **Yes**☐**No**☐
What alternative housing options were explored?	Reason for ruling them out?
Ability to pay cost for temporary relocation?	
Housing options with relatives/friends?	
Other?	

1. Complete the chart below with the name, date of birth, sex, and relationship to Head of Household (HOH) for each person who occupies this unit.

	Name	Date of Birth	Age	Sex	Relationship to Head of Household	Fulltime Student (18+)	Disabled	Child (17 or below)	Elderly (62 +)
HOH						☐	☐	☐	☐
2						☐	☐	☐	☐
3						☐	☐	☐	☐
4						☐	☐	☐	☐

TOTAL ANNUAL/MONTHLY GROSS INCOME: $_____ Proof of Income? **Yes**☐**No**☐

2. What is the racial group and ethnicity for each household member? We need to know this for statistical purposes.

	Name	Race	Ethnicity (Hispanic or Latino)
HOH			**Yes**☐ **No**☐
2			**Yes**☐ **No**☐
3			**Yes**☐ **No**☐
4			**Yes**☐ **No**☐

Race	
American Indian/Alaskan Native	
American Indian/Alaskan Native & Black/African American	
American Indian/Alaskan Native & White	
Asian	
Asian & White	
Black/African American	
Black/African American & White	
Native Hawaiian/Other Pacific Islander	
Other multi-racial	
Unknown	
White	

3. What language do you speak in your home? _____

4. Do you or someone in your household speak/read English? **Yes**☐ **No**☐

5. Is there any information that you can provide that will enable us to better serve your housing needs?
   (disability, i.e., mobility, visual or hearing impairment)

   _____

   _____

   _____

   _____

6. Do you have any pets in the household? **Yes**☐ **No**☐

   If Yes, describe_____

7. Do you own a car? **Yes**☐ **No**☐

8. Do you use public transportation regularly? **Yes**☐ **No**☐ Type_____

9. Although NMHC cannot guarantee that we can meet all of your housing preferences, please note below any factors that impact where temporary housing should be located

Location of employment	
Location of school(s)	
Location of day care/child care provider	
Location related to regular or acute health care needs	
Must be accessible (barrier free)	
Need hearing/sight accommodations	

12. We may need to contact you again to ask additional questions:

   Home Phone: _____   Work Phone: _____

   Email Address:_____

APPLICANT CERTIFICATION

I certify that the information provided in this questionnaire is true and accurate to the best of my/our ability. I understand that if this information is not correct, it may affect the amount of any grant I may receive.

Name (Typed or Printed)	Resident Signature	Date
Name (Typed or Printed)	Resident Signature	Date

WARNING: The information provided on this form is subject to verification by the Commonwealth of the Northern Marianas and the Department of Housing and Urban Development (HUD) at any time. Title 18, Section 1001 of the U.S. Code states that knowingly and willingly making a false or fraudulent statement to a department of the United States Government can result in termination of assistance and civil and criminal penalties.

_____

SURVEYORS USE ONLY:

Name: _____ *Date Surveyed:* _____

Overcrowded: Yes ____ No ____ Obvious Health & Safety Conditions: Yes ____ No ____

Comments _____ _____ _____

_____ _____ _____

_____

4

_____

_____

_____

_____

_____

_____

_____

Attempts:	*Date*	*Time*	*Comment*
1st	_____	_____	_____
2nd	_____	_____	_____
3rd	_____	_____	_____

Call: _____

Reschedule: _____