Harrison Housing Authority
202 W. Stephenson Harrison, AR 72601
Phone: 870-741-8673 Fax: 870-741-6369
contact@arkansasharrisonhousing.org

Application for Admission

Do you or any family member own or have access to any of the following?

Stocks	Yes___ No___	Bonds	Yes___ No___
Real Property (land)	Yes___ No___	Trust Funds	Yes___ No___
Pensions	Yes___ No___	Individual retirement accounts	Yes___ No___
Inheritances	Yes___ No___	Life insurance policies	Yes___ No___

Any other type of capital investment ______________________ Yes___ No___

Explain any "yes" answers below.

Family Member Name	Type of Asset	Account Number	Value

Does any family member have expenses for child care of a child age 12 or younger? Yes___ No___

If yes, complete the following:

Please provide Care Provider Name, Address, and Phone Number below:

Minor's Name	Care Provider Name	Address	Amount Monthly

Is any portion of these childcare expenses reimbursed from an outside agency or person? Yes___ No___
If yes, how much is reimbursed per month? $ ______________________

Do you pay a care attendant to provide care for a disabled family member so that an adult Family member can work? If yes, complete the following: Yes___ No___

Care Attendant Name	Phone Number	Address	Amount Monthly

Are you paying for any type of equipment for a disabled family member that enables an Adult member to work? (Could be the person with disabilities) Yes___ No___

If yes, what is the anticipated monthly cost? ______________________

Indicate the dollar amount for your monthly living expenses as listed below:

Item	Monthly Amount	Last Date Paid	Paid By Whom
Rent	$		
Electricity	$		
Gas	$		
Water	$		
Telephone	$		
TV Cable	$		
Car payment (s)	$		
Car Insurance	$		
Gas for car	$		
Life Insurance	$		
Health Insurance	$		
Loans	$		
Rentals	$		
Furniture	$		
Food	$		
Credit Cards	$		
Other	$		

Medical Expenses (These questions only apply if the head, spouse or co-head is 62 years or older or disabled) Do you or any member of the family pay for any of the following items?

Medical Insurance Premiums? Yes___ No___
Long Term Care Insurance Yes___ No___
Out of pocket prescription expenses Yes___ No___
Past due medical bills Yes___ No___
Other anticipated medical expenses Yes___ No___

Please list the type and amount of the medical expenses for all family members that you anticipate paying over the next 12 months:

Family Member Name	Type of Expense	Amount Monthly

Driver's License or State ID #: Applicant:____________________ Co-applicant:______________________

Automobile: Year:_______ Make:____________ Model:________________ License:__________________