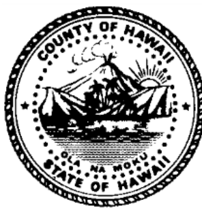
Mitchell D. Roth
Mayor

Lee E. Lord
Managing Director

Robert H. Command
Deputy Managing Director



Susan K. Kunz
Housing Administrator

Harry M. Yada
Assistant Housing Administrator

County of Hawai'i
Office of Housing and Community Development

1990 Kino'ole Street, Suite 102 • Hilo, Hawai'i 96720
V/TT (808) 961-8379 • Fax (808) 961-8685
KONA: 74-5044 Ane Keohokalole Highway • Kailua-Kona, Hawai'i 96740
(808) 323-4300 • Fax (808) 323-4301

RESIDENTIAL REPAIR PROGRAM APPLICATION (RRP)

Application must be filled out COMPLETELY. Please use BLACK Ink to complete application. If any question does NOT apply, please acknowledge by writing NONE or NOT APPLICABLE. Do not leave any section unanswered. Be reminded that questions asked apply to ALL Household members. Please print or type.

PART 1: GENERAL INFORMATION:

APPLICANT
(Head of Household): ____ Phone:________________________
Legal Last Name First Name MI

CO-APPLICANT
(Spouse or Co-Head): ____ Email:________________________
Legal Last Name First Name MI

Current Address: ____ Apt. No.______________

City: __________________ State:________________________ Zip:__________ Yrs. at Residence:__________

Previous address if less than 2 yrs. at above ____ Yrs. at Residence:__________

☐ Check here if mailing address is the same as current address.

Mailing Address: ____ Apt. No._________

City: ________________________________ State:________________________ Zip:_____________

PART 2: HOUSEHOLD MEMBERS:

Starting on first line for the Head of Household, please supply the information for all adults and children that will live in the housing unit to be assisted. List the adults first, then children. Enter one of the following codes in the "Relation" box to identify the household relationship of each adult and child listed.

H = Head of Household **K** = Co-Head (Not Married) **Y** = Youth Under 18 **L** = Live In Aide
S = Spouse (Married) **F** = Foster Child/ Adult **E** = Full Time Student Over 18 **A** = Other Adult

Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation
1					H (Head of Household)
Single Race (select one or more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			
Multi Race (select one or more) [ ] Asian and White [ ] Other Multi-Racial [ ] Black or African American and White [ ] American Indian / Alaska Native and White [ ] American Indian / Alaska Native and Black					

Last Name & Sr, Jr, etc.	First Name	MI	Date of Birth	Sex	Relation
2					

Race (select one or more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			
Name & Sr, Jr, etc. 3	First Name	MI	Date of Birth	Sex	Relation
Race (select one or more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			
Last Name & Sr, Jr, etc. 4	First Name	MI	Date of Birth	Sex	Relation
Race (select one or more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			
Last Name & Sr, Jr, etc. 5	First Name	MI	Date of Birth	Sex	Relation
Race (select one ore more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			
Last Name & Sr, Jr, etc. 6	First Name	MI	Date of Birth	Sex	Relation
Race (select one or more) [ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian / Alaska Native		Ethnicity (check one box) [ ] Hispanic or Latino [ ] Not Hispanic or Latino			

PART 3: ASSET INFORMATION: Please list any checking, savings, stocks, bonds, annuities, savings bonds, credit union shares, trust accounts, retirement contributions, pension contributions, IRAs, certificates of deposit or other assets for everyone in your household. Also include assets that are held ***jointly*** with another person and include the joint holder's name.

Family Member Name	Bank/Credit Union/Financial Institution	Type of Account	Account Number	Estimated Current Balance

PART 4: REAL ESTATE INFORMATION: Please list all real estate owned for everyone for in your household.

Family Member Name	Tax Map Key Number	Current Assessed Value	Mortgage Balance	Monthly Payment	Mortgage Loan No.	Mortgagee Name and Address

PART 5: LIABILITIES: Please list total monthly debt owed; credit cards, car loans, personal loans, etc. except previously listed mortgages.

Family Member Name	Account Type	Balance	Monthly Payment	Account No.	Creditor Name and Address

PART 6: TOTAL INCOME RECEIVED BY FAMILY MEMBERS

APPLICANT (Head of Household):
Current Employment

Employer: ____

Position Held: ____ Years of Employment:__________________

Employer Address: ____

Phone: ____ Gross Monthly Income: $__________________

CO-APPLICANT (Spouse or Co-Head):
Current Employment

Employer: ____

Position Held: ____ Years of Employment:__________________

Employer Address: ____

Phone: ____ Gross Monthly Income: $__________________

If the current employment is for less than 2 years, complete the following:

	Previous Employment	Years Employed	Last Position Held	Monthly Income
APPLICANT	______________________	__________	__________	__________
CO-APPLICANT	______________________	__________	__________	__________

OTHER GROSS MONTHLY INCOME
Please list gross payments (before taxes) made to **each family member**, for wages, worker's compensation, social security, SSI, disability, welfare assistance, unemployment benefits, retirement payments, child support, pension, military pay, and business or professional income.

Family Member Name	Source of Income	Address of Source	Gross Monthly Amount

YES NO
[ ] [ ] Did you file a Federal Income Tax Return for the last full calendar year?

YES NO
[ ] [ ] Did you file a State Income Tax Return for the last full calendar year?

YES NO
[ ] [ ] Has anyone in your household applied for any benefit or money which is in the process of being approved? If YES, please indicate what household member and for what benefit:
____
____

PART 7: CHILD CARE PROVIDER ALLOWANCE:

☐ ***Check here if the following does not apply to your household.***

Un-reimbursed Child Care Expense

If you pay (and are not reimbursed) for a care provider to care for a child under the age of 13 who is a member of your family so that an adult member of your family may work or attend classes, enter the first name of the person who works or attends classes here ____________________________, and provide the following information:

Name and Address of Care Provider for Verification:

Name: _______________________________________ Address:____

City: ________________________ State: _________ Zip_______________ Telephone:______________________

Date Child Care Began: ______________________________ Average Hours Per Week: ______________________

Total Child Care Cost: _________________________

Amount you Pay ($):_________________________ (circle one) per hour per week per bi-weekly per month

Amount Reimbursed by an individual/ organization: $ ____________________

Name and Address of Organization: ____

PART 8: DISABILITY ASSISTANCE EXPENSE:

☐ ***Check here if the following does not apply to your household.***

Un-reimbursed Disability Assistance Expense

If you pay (and are not reimbursed) for care or equipment for a disabled member of your family so that either the disabled member or another member of your family may work, enter the first name of the person who works here ____________________________, and provide the following information:

Name and Address of Care or Equipment Provider for Verification:

Name: _______________________________________ Address:____

City: ________________________ State: _________ Zip_______________ Telephone:______________________

PART 9: MEDICAL EXPENSE ALLOWANCE:

Complete only if the Head of Household, Spouse, or Co-Head is disabled or age 62 or older.

☐ ***Check here if the following does not apply to your household.***

If you wish to claim an allowance for medical insurance premiums, medical, dental or optical expenses, or prescription or over-the-counter drug expenses, please provide the first name of any family member claiming each expense and the name and address of the provider of the service or product.

YES	NO		
[ ]	[ ]	Do you have Medicare (Social Security)?	If YES, Monthly Premium Amount: $ _________
[ ]	[ ]	Do you have Medicaid (Welfare)?	
[ ]	[ ]	Do you have other Medical Insurance?	If YES, Monthly Premium Amount: $ _________
[ ]	[ ]	Are you paying on any medical bills?	If YES, Monthly Premium Amount: $ _________
			Balance Amount: $ _________

Family Member First Name : ____________________	**Family Member First Name :** ____________________
Expense Claimed: $ __________________________	**Expense Claimed: $** __________________________
Provider: ____________________________________	**Provider:** ____________________________________
Address: ____________________________________	**Address:** ____________________________________
City: _______________ **State:** _______ **Zip:** _______	**City:** _______________ **State:** _______ **Zip:** _______

PART 10: REPAIR WORK NEEDED:

Give a brief description of the repair work needed:

____
____
____
____
____
____
____
____
____
____
____

PART 11: APPLICANT'S CERTIFICATION

GIVING TRUE AND COMPLETE INFORMATION

I (We), the undersigned, certify that all of the information provided in this application is true and correct to the best of my (our) knowledge and is submitted for the purpose of the Residential Repair Program. I/We understand that the above information is being collected to determine my (our) eligibility and is submitted for the purpose of obtaining a County rehabilitation loan. I (We) authorize the County of Hawai`i to verify all information contained herein and agree that this application and related verification and statements shall remain the property of the County of Hawai`i.

____ ___________________________

(Signature of Applicant) Date

____ ___________________________

(Signature of Other Household Adult Member) Date

____ ___________________________

(Signature of Other Household Adult Member) Date

____ ___________________________

(Signature of Other Household Adult Member) Date