SSI STATE SUPPLEMENTAL PAYMENTS PROGRAM
SELF-CERTIFICATION FORM

Check off one (1) of the following three (3) options:

_____
Recipient name

____ 1. receives SSI State Supplemental Payments in the amount of $_____every _____ from Department of Human Services for the State of Rhode Island. This amount is received in addition to the amount I received from the Social Security Administration (SSA).

____ 2. previously received SSI State Supplemental Payments in the amount of $_____ every _____ but the payments stopped on _____. (Provide the letter from DHS verifying when your benefit ended)

____ 3. does not receive SSI State Supplemental Payments

I am aware that whenever there is a change in income (start receiving, stop receiving, change in amount etc.), it is my obligation to report this income change in writing within ten (10) business days.

I understand that failure on my part to report changes in my income may result in a repayment agreement and/or the termination of my participation in the Voucher Program.

Under penalties of perjury, I certify that the above information is true and complete. My rental assistance can be terminated and I can be fined or imprisoned if I furnish false or incomplete information.

_____ _____
Tenant Signature Date