



Carlos A. Gimenez, Mayor  
[www.miamidade.gov](http://www.miamidade.gov)

**Public Housing and Community Development  
 Miami-Dade Housing Choice Voucher Program**

P.O. Box 521750  
 Miami, FL 33152-1750  
 TTD/TTY Florida Relay Service  
 1-800-955-8771 or Dial 771

Customer Service Number: 305-403-3222/ Fax: 786-358-5893  
 Si necesita ayuda con este formulario, llame al 305-403-3222  
 Si w bezwen asistans ak fòm sa a, tanpri rele 305-403-3222

**REQUEST FOR INTERIM RECERTIFICATION**

Participant Name:		Address of Unit:	
Entity ID:	Telephone Number:	Email:	

As a Participant in the Miami-Dade County Housing Choice Voucher (HCV) Program, you have the right to request an interim re-examination appointment due to a change in income or household composition or to request the addition of a Live-In Aide. Please indicate below the reason for your request (check all that apply):

- Change in Income
  - Increase     Decrease
- Change in Household Composition
  - Reduction in household member
  - Addition of a family member due to brith, adoption or court-awarded custody
- Request Addition of a Live-In Aide
- Other: \_\_\_\_\_

If you are reporting a change in income, please provide the family member name(s) and information below:

Income Increase or Decrease. List all changes to household income:		
Pevious Income Source and Amount	Current Income Source and Amount	Temporary or Permanent Change?

If you are reporting or requesting a change in household composition, please provide the family member name(s) and information below. Please note that any addition to the household that is not due to birth, adoption or court awarded custody must be approved by Miami-Dade HCV prior to the household member moving in to the unit.

Family Composition Change. List all family members requested to be added or removed.					
Name:	Soc. Sec. Number:	Sex:	Race:	Ethnicity:	Elderly and/or Disabled?
Relationship to Head of Household:	Birth date:	Moving In or Out?		Live-in Aide?	
Name:	Soc. Sec. Number:	Sex:	Race:	Ethnicity:	Elderly and/or Disabled?
Relationship to Head of Household:	Birth date:	Moving In or Out?		Live-in Aide?	

**I hereby certify that the above information is true and correct to the best of my knowledge.**

Signature of Head of Household: \_\_\_\_\_ Date: \_\_\_\_\_

If you need this document in a different language or **LARGER FONT** or if you need a reasonable accommodation (persons with disabilities), please call 305-403-3222; TDD/TTY 1-800-955-8771, between 8:00am and 5:00pm, Monday through Friday. Advance notice of five (5) business days is required in order to arrange for interpreter services.

