

# HIGHTSTOWN HOUSING AUTHORITY

131 ROGERS AVENUE, HIGHTSTOWN, NJ 08520  
PHONE: 609-448-2268 FAX: 609-426-9440

## COMMUNITY SERVICE/SELF SUFFICIENCY POLICY

### A. Background

The Quality Housing and Work Responsibility Act of 1998 requires that all non-exempt (see definitions) public housing adult residents (18 or older) contribute eight (8) hours per month of community service (volunteer work) or participate in eight (8) hours of training, counseling, classes and other activities which help an individual toward self-sufficiency and economic independence. This is a requirement of the dwelling lease signed with all residents of the Hightstown Housing Authority (HHA)

HHA requires residents to verify compliance annually, at least 30 days before the expiration of the lease term. Self-certification by residents is not acceptable; third party certification must be provided by the entity with whom the resident is working.

### B. Definitions

**Community Service** – volunteer service that includes, but is not limited to:

- Service at a local school, church, hospital, recreation center, senior center, service organization, or child care center
- Service with youth or senior organizations, including Police Athletic League (PAL) events and functions
- Working and participating on Resident Council.
- Caring for the children of other residents so they may volunteer
- Other volunteer service with non-profits, for example, 501(C)(3) organizations, providing community service programs.

**NOTE: Any Political activity is excluded such as campaign work.**

**Self-Sufficiency Activities** – activities that include, but are not limited to:

- Family Investment Center programs
- Job training programs
- GED classes
- Substance abuse or mental health counseling
- English proficiency or literacy (reading) classes
- Budgeting and credit counseling
- Homeownership educational programs or seminars (offered by other community organizations)
- Any kind of class that helps a person move toward economic independence

**Exempt Adult** – *an adult member of the family who*

- Is 62 years of age or older
- Is a blind or disabled individual, as defined under 216(i)(1) or 1614 of the Social Security Act (42 U.S.C. 416(i)(1); 1382c) and who certifies that because of such disability she or he is unable to comply
- Is the caretaker of such a blind or disabled *individual*
- Is working at least 30 hours per week
- Is participating in a welfare to work program
- Is receiving assistance from TANF and is in compliance with job training and work activities requirements of the program
- Each adult member of the household must sign a Community Service Exemption Certification at each annual recertification or if they become an “exempt adult” at any time between recertifications that the status should change. This form would be signed at move-in and during interim recertification conferences with the Housing Manager.

### **C. Requirements of the Program**

1. The eight- (8) hours per month may be either volunteer service or self-sufficiency program activity or a combination of the two.
2. At the time of move-in and at each recertification, all adult members of the household must sign a “Community Service Compliance Certification indicating they have read and understand the housing authority’s Community Service/Self-Sufficiency Policy.
3. At least eight (8) hours of activity must be performed each month. An individual may not skip a month and then double up the following month, unless special circumstances warrant consideration. The Executive Director or his designee will make the determination of whether to allow or disallow a deviation from the schedule.
4. Activities must be performed within the community and not outside the jurisdictional area of Hightstown Housing Authority.

## 5. Family obligations

- At lease execution or re-examination, all adult members (18 or older) of a public housing resident family must:
  - 1) Provide documentation that they are exempt from the Community Service requirement.
- At each annual re-examination, non-exempt family members must present a completed documentation form of activities performed over the previous twelve- (12) months. This form will include places for signatures of supervisors, instructors, or counselors certifying to the number of hours contributed.
- If a family member is found to be noncompliant at re-examination, he/she and the Head of Household will sign an agreement to make up the hours.

If the Executive Director feels the resident has extenuating circumstances which have prevented them from completing this requirement timely and said circumstances can be documented by the resident, the Executive Director may make a recommendation for a longer period of time to be granted.

## 6. Change in exempt status:

- If, during the twelve- (12) month period, a non-exempt person becomes exempt, it is his/her responsibility to report this to the management office during an interim recertification and provide documentation of such. (Exhibit “6”)
- If, during the twelve- (12) month period, an exempt person becomes non-exempt, it is his/her responsibility to report this to the management office. Management offices will provide the person with the Recording/Certification documentation form.

## D. HHA obligations

1. To the greatest extent possible and practicable, HHA will provide a list of opportunities for volunteer service or self-sufficiency programs for residents, including disabled, to fulfill their Community Service obligations. (*According to the Quality Housing and Work Responsibility Act, a disabled individual who is otherwise able to perform community service is not necessarily exempt from the Community Service requirement*).
2. HHA’s Executive Director will make the final determination as to whether or not a family member is exempt from the Community Service requirement. Residents may use the Grievance Procedure if they disagree with HHA’s determination. (Section 18 of the dwelling lease).
3. Non-compliance of family member. The responsibility for enforcement will be with the Executive Director

- If HHA finds a family member to be non-compliant, the Housing staff will enter into an agreement with the non-compliant member and the head of household to make up the deficient hours over the next twelve- (12) month period.
- If, at the next annual re-examination, the family member still is not compliant, the lease will not be renewed and the entire family would be issued a 30-day notice to vacate by the Executive Director, unless the non-compliant member agrees to move out of the unit and a new lease is signed with the family amending its composition accordingly.
- The family may use the Grievance Procedure to appeal the lease termination, after attending a private conference with the Housing Manager/Aide or other representative of HHA.

# Hightstown Housing Authority

## COMMUNITY SERVICE EXEMPTION CERTIFICATION

I certify that I am eligible for an exemption from the Community Service requirement for the following reason:

I am 62 or older.

I am 18 Years and Over – *Full Time Student*

***I am blind. The term blind means that I have central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. 42 U.S.C. 416(i)(1);1382c. Or, I am disabled. The term means that I am unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C. 416(i)(1);1382c. And, because of such blindness/disability, I cannot perform voluntary work or duties that are a public benefit, and that serve to improve the quality of life, enhance resident self-sufficiency or increase resident self-responsibility in the community. If I receive SSI or SSD benefits then I have no further reporting duties to the HHA for this exemption period. However, if I do not receive SSI or SSD benefits, then I will also have to provide medical documentation or complete the HHA's medical verification forms so that the HHA may verify my status as blind or disabled individual.***

I am disabled. If I do not receive SSI or SSD benefits, then I will also have to provide medical Documentation or complete HHA's medical verification forms so that HHA may verify my status as a disabled individual.

I am the primary caretaker of such blind or disabled individual who satisfies the above criteria and I am submitting HHA medical exemption form for verification.

I am the primary caretaker for minor children which allows my spouse or domestic partner to work full time. (*Employment Verification form will serve as documentation*)

I am working at least 30 hours per week.  
(*Employment Verification form will serve as documentation*)

I am participating in a Welfare to Work Program  
(*Must provide verification letter from agency*)

I am receiving TANF and am participating in a required economic self-sufficiency program or work activity  
(*Must provide verification from the funding agency that you are complying with job training or work requirements. A certification form must be signed by each adult member of the household.*)

\_\_\_\_\_  
Resident Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

# HIGHTSTOWN HOUSING AUTHORITY

131 ROGERS AVENUE, HIGHTSTOWN, NJ 08520  
PHONE: 609-448-2268 FAX: 609-426-9440

Community Service Verification  
Physicians Verification

Date: \_\_\_\_\_

\_\_\_\_\_  
(Physician/Medical Office)\_\_\_\_\_

\_\_\_\_\_  
(Address)

We are required by the U.S. Department of Housing and Urban Development to verify the below listed tenant participation in qualified community service. Community Service is defined as:

“the performance of voluntary work or duties that are a public benefit, and that serve to improve the quality of life, enhance resident self-sufficiency, or increase resident self-responsibility in the community” Community Service is not employment and may not be political activities.

We would greatly appreciate your prompt return of this letter. A self-addressed return envelope is enclosed. Note that the person referenced has authorized your release of the information.

If you have any questions, please call the office Monday through Friday from 8:00AM to 4:00PM.

Sincerely,

Mr. Allen Keith LePrevost  
Executive Director

---

Dear Sir or Madam:

Re: \_\_\_\_\_  
\_\_\_\_\_

Please Verify the Following:

- The above listed patient is incapable of performing any type of community service due to their existing and ongoing conditions.

Name of Physician Completing this Form: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

---

Applicant/Tenant Release I \_\_\_\_\_ hereby authorize the release of the requested information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# HIGHTSTOWN HOUSING AUTHORITY

131 ROGERS AVENUE, HIGHTSTOWN, NJ 08520  
PHONE: 609-448-2268 FAX: 609-426-9440

## Community Service Verification

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

We are required by the U.S. Department of Housing and Urban Development to verify the below listed tenant participation in qualified community service. Community Service is defined as:

“the performance of voluntary work or duties that are a public benefit, and that serve to improve the quality of life, enhance resident self-sufficiency, or increase resident self-responsibility in the community” Community Service is not employment and may not be political activities.

We would greatly appreciate your prompt return of this letter. A self-addressed return envelope is enclosed. Note that the person referenced has authorized your release of the information.

If you have any questions, please call the office Monday through Friday from 8:00AM to 4:00PM.

Sincerely,

Mr. Allen Keith LePrevost  
Executive Director

---

Dear Sir or Madam:

Re: \_\_\_\_\_  
\_\_\_\_\_

Please Verify the Following:

- Organization is a registered 501C-3 or qualified government entity Y/N
- Above mentioned person is actively providing Community Service Y/N
- Type of service provided (please list) \_\_\_\_\_
- Approximate number of hours per month \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Signature: \_\_\_\_\_

---

Applicant/Tenant Release I \_\_\_\_\_ hereby authorize the release of the requested information.

Signature

Date

## Request for a Reasonable Accommodation

The following member of my family has a handicap/disability:

\_\_\_\_\_

*(Do not tell the HHA the name of your disability or the nature or extent of your disability.)*

Please provide this reasonable accommodation:

\_\_\_\_\_  
\_\_\_\_\_

A reasonable accommodation is needed because:

- \_\_\_\_\_ It will help you live in the housing or take part in HHA's program;
- \_\_\_\_\_ It will help you meet the lease requirements of HHA's program;
- \_\_\_\_\_ It will help you meet other requirements of HHA's program.

Physician, Health Care Provider's name, address and telephone number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing below you confirm the accuracy of the information submitted above. You will be mailed by the HHA an "Authorization for Release of Medical Information" which will be forwarded to your physician, medical provider. Your physician/medical provider will then be required to confirm your eligibility and accommodation request to HHA. Once this process has been completed, your Housing Manager will be in contact with you.

\_\_\_\_\_  
Tenant's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Tenant's Address

**Do not write below line**

\_\_\_\_\_  
For Office Use Only

Date Received by Housing Operations: \_\_\_\_\_

Date Authorization for Release of Medical Verification sent to Tenant: \_\_\_\_\_

Date Medical Verification letter sent to physician, health care provider: \_\_\_\_\_



**Community Service Requirement in HUD Appropriations**

Under section 12 of the United States Housing Act of 1937, as amended, every adult resident of public housing is required to perform eight hours of community service each month, or participate in a self-sufficiency program for at least eight hours each month or a combination of the two totaling eight hours each month. (42 USC 1437j) This requirement does not apply to various exempt groups such as elderly persons, certain disabled individuals and others. (24 CFR 960.600-609).

**Hightstown Housing Authority Community Service/Self-Sufficiency Policy  
Informational Sheet**

- Community Service is required for all residents who are not working at least 30 hours per week or involved in a self-sufficiency program with all annual recertification's effective July 1, 2003 and thereafter;
- **Residents who are elderly, handicapped or disabled may be exempted from community service;**
- Residents are required to verify community service – 8 hours per month – at the time of their annual recertification with HHA. (Please see your Housing Manager for a log sheet to track your volunteer hours);
- Residents may choose where they complete their community service hours;
- Residents caring for an elderly or disabled family member may be exempted from community service (Please see your management office for the proper documentation.);
- Resident Council, and other volunteer opportunities can be documented for Community Service credit;
- Management offices may hold verification of community service hours in your file until your next annual recertification, if requested;
- HHA must enforce the community service policy in accordance with the Quality Housing and Work Responsibility Act (QHWRA) of 1998;
- Community service may not include political activities;
- Failure to comply with the community service requirements can result in the termination of your lease.

**Community Service benefits all residents!**

By signing below you are verifying that you understand the community service requirements according to The Quality Housing and Work Responsibility Act of 1998 and have been provided with a copy of this signed document.

\_\_\_\_\_  
Adult Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult Signature

\_\_\_\_\_  
Date

Month \_\_\_\_\_ Year \_\_\_\_\_

**HIGHTSTOWN HOUSING AUTHORITY  
RESIDENT COMMUNITY SERVICE/SELF-SUFFICIENCY  
MONTHLY TIME SHEET  
QUALITY HOUSING AND WORK RESPONSIBILITY ACT OF 1998**

Name of Resident \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

**It is the responsibility of each resident to submit a signed, fully completed time sheet to the Housing Authority Office for required verification at the close of each month, please submit no later than the 5<sup>th</sup> business day of each month.**

---

Name and Address of Agency for which Community Service is performed: **Please PRINT Clearly**

\_\_\_\_\_  
\_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Telephone # \_\_\_\_\_

Date	Start Time	End Time	Type of Service Performed	Type of Training/Education Program	Supervisor's Signature	# of Hours

Signature of Tenant \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE – FOR OFFICAL USE ONLY**

---

Community Service Hours Verified \_\_\_\_\_ Date \_\_\_\_\_

Total Hours posted to the Community Service Ledger for Tenant \_\_\_\_\_

Housing Authority Representative Signature \_\_\_\_\_



# HIGHTSTOWN HOUSING AUTHORITY

131 ROGERS AVENUE, HIGHTSTOWN, NJ 08520  
PHONE: 609-448-2268 FAX: 609-426-9440

## AGREEMENT

In accordance with the provisions of HUD/HHA's Community Service/Self-Sufficiency policy, I/We agree to complete all deficient service hours over the next 12-month period. Deficient service hours are for the review year \_\_\_\_\_ and will be completed by \_\_\_\_\_.

I/We understand that HHA may issue a 30-day notice if the service hour requirements of your lease are not brought into compliance by \_\_\_\_\_. I/we understand what volunteer work qualifies as community service and what types of programs qualify for self-sufficiency participation.

\_\_\_\_\_  
Head of Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other Adult Resident

\_\_\_\_\_  
Date

-----  
HHA USE ONLY

APPROVED BY: \_\_\_\_\_

Allen Keith LePrevost

\_\_\_\_\_  
Date

Schedule to Make-Up Deficient Hours

<b>HOURS DEFICIENT</b>	<b>NUMBER OF MONTHS TO COMPLETE HOURS</b>
8	1
16	2
24	3
32	4
40	5
48	6
56	7
64	8
72	9
80	10
88	11
96	12

\*Does not include hours for present year recertification requirement

# HIGHTSTOWN HOUSING AUTHORITY

131 ROGERS AVENUE, HIGHTSTOWN, NJ 08520  
PHONE: 609-448-2268 FAX: 609-426-9440

\_\_\_\_\_  
(Date)

Dear \_\_\_\_\_:

Please be advised that HHA has not received documentation evidencing completion of 96 hours of community service for the following members of your family:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All non-exempt adult members of the family must complete the community service hours as a part of the annual recertification process. If you feel one or more of the above listed family members may be eligible for an exemption, please see your management office.

You may also be eligible to enter into an agreement to complete deficient service hours.

In the event service hours have not been completed for all adult members, you can be issued a 30-day notice to vacate. Your cooperation in this matter is needed to assist in preserving your housing opportunity.

Sincerely,

\_\_\_\_\_  
Executive Director

Cc: Resident file

## Caretaker Verification for Community Service Exemption

***I certify that I am blind or disabled. I understand that HHA will keep this information strictly confidential. I agree to provide proof of receipt of SSI or SSD benefits. If I do not receive SSI or SSD benefits then I agree to provide medical documentation of such status or cooperate with HHA to verify such status.***

***And, because of such blindness or disability, I cannot perform voluntary work or duties that are a public benefit, and that serve to improve the quality of life, enhance resident self-sufficiency or increase resident self-responsibility in the community.***

I certify that \_\_\_\_\_ is my primary caretaker.  
Resident Name

\_\_\_\_\_ resides at \_\_\_\_\_.  
Resident Name Resident Address

\_\_\_\_\_  
(Signature of Person Certifying  
About her/his Caretaker)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address