Agency Name
Address
Phone Number, Fax Number

Continuum of Care (CoC) Program

NON-INCOME AFFIDAVIT
STATEMENT OF SOLE SUPPORT
(Part B)

List the name of the household member who is 18 years or older and does not have a source of income:

Name of Household Member	Social Security #	Age
_____	_____	_____

I HEREBY STATE THAT I PROVIDE SUPPORT FOR THE ABOVE HOUSEHOLD MEMBER 18 YEARS OR OLDER WHO DOES NOT HAVE A SOURCE OF INCOME TO THE EXTENT THAT I PAY THEIR PART OF THE RENT, FOOD AND OTHER NECESSITIES TO SURVIVE FROM MY INCOME.

***Pursuant to 28 U.S.C. Section 1746, I hereby certify under penalty or perjury that he foregoing is true and correct:**

Printed Name: _____

Signature: _____

Date: _____

***Warning:** HUD will prosecute false claims and statements. Conviction may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)

_____
Sponsor Agency Staff / Date