



TANNERY VILLAGE APARTMENTS
47 Richardson Avenue
Monticello, NY 12701
(518) 794-2975
TDD Relay 711

(ALL BLANKS MUST BE FILLED IN OR THIS FORM WILL BE RETURNED TO YOU)

OFFICE USE ONLY: DATE RECEIVED _____ TIME RECEIVED _____

THIS FORM SHOULD BE COMPLETED IN YOUR OWN HANDWRITING. YOU MUST USE THE CORRECT LEGAL NAME FOR EACH MEMBER OF YOUR HOUSEHOLD AS IT APPEARS ON THE SOCIAL SECURITY CARD. LIST APPLICANT FIRST, CO-APPLICANT SECOND, OTHER MEMBERS OF HOUSEHOLD THIRD, ETC. ALL INFORMATION IS KEPT CONFIDENTIAL.

(If you are unable to fill out this application, someone will fill it out for you or you may choose someone to fill it out. That person must sign the last page as the person whose hand-writing appears on the form.)

APPLICANT'S NAME _____
 PRESENT ADDRESS _____

PHONE NO. _____
 RENT: \$ _____
 UTILITIES INCLUDED? _____

A. LIST ALL PERSONS WHO WILL BE LIVING IN YOUR HOME.

NAME	DATE OF BIRTH	RELATION TO HEAD OF HOUSE	SOCIAL SECURITY # (FOR ALL)	FULL TIME STUDENT? (Y/N)
		HEAD OF HOUSEHOLD		
		CO-TENANT		

B. Do you have any unusual expenses related to employment, such as a care attendant or auxiliary apparatus for a handicapped or disabled family member? Yes ___ No ___ If yes, please explain:

Will any alterations to the apartment be necessary for you or a member of your family? Yes ___ No ___ If yes, please explain: _____

What apartment size are you applying for? _____ Bedroom(s)

Do you require a handicap accessible unit or reasonable accommodation due to disability? ___Yes ___No

C. INCOME: LIST ALL SOURCES OF INCOME AS REQUESTED BELOW. ENTER ZERO (\$0) FOR ANYTHING THAT DOES NOT APPLY.

NAME OF FAMILY MEMBER _____

SOURCE OF INCOME _____

- | | | |
|----------------------------|--------------------------------------|----------|
| _____ a. | Social Security Gross monthly amount | \$ _____ |
| _____ | Social Security Gross monthly amount | \$ _____ |
| _____ b. | Pension monthly amount | \$ _____ |
| _____ | Pension monthly amount | \$ _____ |
| Source of Pension(s) _____ | | |
| _____ c. | SSI Benefits monthly amount | \$ _____ |
| _____ | SSI Benefits monthly amount | \$ _____ |
| _____ d. | Wages Gross monthly amount | \$ _____ |

Employer's Name _____
Employer's Address _____

Wages Gross monthly amount \$ _____

Employer's Name _____
Employer's Address _____

- | | | |
|--------------|---------------------------------|----------|
| _____ e. | Unemployment Comp. monthly amt. | \$ _____ |
| _____ | Unemployment Comp. monthly amt. | \$ _____ |
| _____ f. | Social Services monthly amount | \$ _____ |
| _____ | Social Services monthly amount | \$ _____ |
| _____ g. | Full Time Student over 18 | \$ _____ |
| _____ | Full Time Student over 18 | \$ _____ |
| _____ h. | Alimony monthly amount | \$ _____ |
| _____ i. | Child Support monthly amount | \$ _____ |
| _____ j. | Earned Income | |
| _____ k. | Tax Credit ANNUAL amount | \$ _____ |
| _____ | Other Income monthly amount | \$ _____ |
| Source _____ | | |
| _____ | Other Income monthly amount | \$ _____ |
| Source _____ | | |
| _____ l. | Income from investments monthly | \$ _____ |
| _____ | Income from investments monthly | \$ _____ |
| _____ m. | Interest income monthly amount | \$ _____ |
| _____ | Interest income monthly amount | \$ _____ |

Do you anticipate any changes in this income during the next 12 months? Yes _____ No _____

Does anyone in the household receive any regular contributions or gifts from non-household members?
Yes _____ No _____

Does anyone in the household receive any income from property? Yes _____ No _____ Explain _____

Do you expect anyone not listed on this application to be moving in with you in the future?
Yes _____ No _____

Is either the Head of Household or Co-head a full-time student or expected to be in the next 12 months?
Yes _____ No _____

D. PLEASE LIST ALL ASSETS FOR ALL HOUSEHOLD MEMBERS (Bank checking, savings accounts, credit union accounts, C.D.'s, stock)

	ACCOUNT NUMBER	BANK	BALANCE	INTEREST RATE
Checking Account	# _____	_____	_____	_____
	# _____	_____	_____	_____
Cash On Hand	_____	_____	_____	_____
Savings Account	# _____	_____	_____	_____
	# _____	_____	_____	_____
Credit Union	# _____	_____	_____	_____
	# _____	_____	_____	_____
C.D.'s	# _____	_____	_____	_____
	# _____	_____	_____	_____
Savings Bonds	# _____	_____	_____	_____
	# _____	_____	_____	_____
Other (property held as an investment or life insurance cash value)	# _____	_____	_____	_____
	# _____	_____	_____	_____

Real Property: Do you own any property? Yes _____ No _____
 If yes, type of property _____
 Where is property located _____
 Appraised Market Value \$ _____

Have you sold/disposed of any property in the last 2 years? Yes _____ No _____
 If yes, type of property _____
 Market Value when sold/disposed \$ _____
 Date of transaction _____

Have you disposed of any other assets in the last 2 years (Example: Given away money to relatives, set up irrevocable trust accounts)? Yes _____ No _____ If yes, describe asset _____
 Date of Disposition _____
 Amount disposed \$ _____

Do you have any other assets not listed above (excluding personal property)? Yes _____ No _____
 If yes, list _____

E. MEDICAL/CHILD CARE/HANDICAP ASSISTANCE EXPENSES

A deduction is allowed for households whose head or co-head is elderly, (62 or older), handicapped or disabled (regardless of age).

Are you or anyone in your household seeking this deduction? Yes _____ No _____

If yes, you must provide evidence in the form of a statement by a qualified individual. THE NATURE OF A HANDICAP OR DISABILITY DOES NOT HAVE TO BE DISCLOSED.

Medical Costs: Complete this part ONLY if Head of Household or Co-Tenant is age 62 or older, or Disabled or Handicapped (regardless of age).

Medicare Premiums Monthly Amount \$ _____
 Monthly Amount \$ _____

Medical Insurance Coverage - Insurer's Name _____

Address _____

Monthly Amount \$ _____

Anticipated Medical/Drug/Prescription costs NOT covered by insurance or reimbursed:

Monthly Amount \$ _____

Medical Bills or outstanding costs YOU are making monthly payments for:

Balance Due \$ _____ Monthly Payments \$ _____ Payable to: _____

Name and Address of all Physicians you are seeing on a regular basis:

Any other medical expenses: Type _____

Amount _____

CHILD CARE Costs: Complete ONLY for children 12 and younger:

Names of children cared for _____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Name and Address of Person or Agency caring for children _____

Weekly cost for children due to employment or education \$ _____

HANDICAP ASSISTANCE EXPENSES: Complete ONLY if Handicap Expenses allow a member of the household to work or attend school. List type of expenses, weekly amount, paid to whom:

F. REFERENCES:

1. Current Landlord: Name _____
Address _____
Phone Number _____

2. Prior Landlord: Name _____
Address _____
Phone Number _____

3. Are you currently under eviction or have you ever been evicted or refused to pay rent? Yes _____ No _____.
If so, why _____

4. Are you a current illegal user of controlled substance or have you ever been convicted of using a controlled substance? _____ Yes _____ No

5. Are you a drug dealer or have you ever been a drug dealer? Yes _____ No _____

6. If you answered yes to either question F4 or F5 above, have you successfully completed a controlled substance abuse recovery program or are you presently enrolled in such a program? ___Yes ___No

CRIMINAL HISTORY: Have you or any household member:

1. Ever been convicted or pleaded "no contest" to a crime (whether or not resulting in a conviction)? ___Yes ___No If yes, what State/County? _____
When? _____

2. Ever been convicted of or pleaded guilty or "no contest" to a crime involving sexual misconduct (whether or not resulting in a conviction)? ___Yes ___No
If yes, what State/County? _____ When? _____

3. Are you or any member of your household a Registered or Unregistered Sex Offender? ___Yes ___No

CREDIT REFERENCES:

1. Name _____ Address _____ Phone _____

2. Name _____ Address _____ Phone _____

3. Name _____ Address _____ Phone _____

PERSONAL REFERENCES (NO RELATIVES)

1. Name _____ Address _____ Phone _____

2. Name _____ Address _____ Phone _____

3. Name _____ Address _____ Phone _____

IN CASE OF EMERGENCY NOTIFY: _____
Address _____ Phone Number _____

LIST YEAR, MAKE, COLOR AND LICENSE PLATE # FOR ALL VEHICLES IN YOUR HOUSEHOLD

YEAR/MAKE	COLOR	LICENSE PLATE #
_____	_____	_____
_____	_____	_____

Do you own any pets: Yes ___ No ___ If yes, describe _____

Acceptance of this application does not guarantee rental of an apartment. All applicants must meet screening criteria, including landlord and credit checks. Changes in family income, size and address and phone number must be reported promptly to management in order to properly process your application.

A security deposit and a one year lease are required. Copies of birth certificates will be required for all household members.

I/We certify that all information in this application is true to the best of my/our knowledge and that I/We understand that false statements or information are punishable by law and will lead to cancellation of this application or termination of tenancy after occupancy. I/We certify that if accepted for tenancy, this unit will be my/our primary residence and I/we will not maintain a separate subsidized rental unit in a different location.

SIGNATURES:

Applicant

Co-Applicant

Date Signed

Date Signed

AUTHORIZATION

I/WE DO HEREBY AUTHORIZE BELMONT MANAGEMENT CO., INC. AND ITS STAFF OR AUTHORIZED REPRESENTATIVES TO CONTACT ANY AGENCIES, OFFICES, GROUPS OR ORGANIZATIONS TO OBTAIN AND VERIFY ANY INFORMATION OR MATERIALS WHICH ARE DEEMED NECESSARY TO COMPLETE MY/OUR APPLICATION FOR HOUSING IN THIS PROPERTY MANAGED BY BELMONT MANAGEMENT CO., INC.

SIGNATURES:

Applicant

Co-Applicant

Date Signed

Date Signed

Signature of Person Filling Out
Form for Tenant

*RACE/NATIONAL ORIGIN: COMPLETION OF THIS SECTION IS OPTIONAL

*The information regarding race, ethnicity, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the Rural Housing Services, that the Federal laws prohibiting discrimination against tenant applications on the basis of race, color, national origin, religion, sex, familial status, age, and disability are complied with. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, the owner is required to note the race, ethnicity, and sex of individual applicants on the basis of visual observation or surname.

APPLICANT #1

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

- White
- Black or African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander

Gender:

- Male Female

APPLICANT #2

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

- White
- Black or African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander

Gender:

- Male Female

Unlawful discrimination. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, disability, religion or familial status. (Not all prohibited bases apply to all programs. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TDD)." In addition, in accordance with the New York State Statute, we do not discriminate on the basis of age or sexual orientation.

Non-Smoking Application Addendum

Property: _____

In order to protect the health of our residents and employees, this facility has been designated a **non-smoking** facility. That means that there is no smoking in the building (including the apartments) or within fifty feet of the building by anyone, including tenants, guests, employees, vendors or contractors.

Do you smoke? Yes No

Do you understand our smoking policy and agree to adhere to it should your application be approved and you are accepted for residency?

Yes No

(If no, please understand that you cannot be accepted for occupancy since you are not willing to abide by the terms and conditions of the Lease Agreement.)

I understand the smoking policy and agree to abide by it if my application is approved.

Applicant Signature

Date

FRAIL ELDERLY ANALYSIS

Name:

Project:

Apt. No.:

Activities of Daily Living

Assistance Needed for:

- Bathing
- Dressing
- Eating
- Transferring: Moving between bed and chair/wheelchair
- Grooming/Personal Hygiene
- Toileting: Getting to/from & transferring on/off toilet
- Mobility: Moving about by self or with adaptive equipment

Instrumental Activities of Daily Living

Assistance Needed for:

- Shopping
- Getting to places out of walking ability
- Laundry
- Housework/cleaning
- Chores
- Prepare/cook meals
- Handle personal business/finances
- Use the telephone
- Self-administer medications

By:

Date:

Referral(s):