



**CHARLOTTE VILLA II**  
**3 Church Street**  
**Sinclairville, NY 14782**  
**(716) 962-8419/Fax (716) 962-2189**  
**TDD Relay 711**

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

**OFFICE USE ONLY:** DATE RECEIVED \_\_\_\_\_ TIME RECEIVED \_\_\_\_\_  
 MANAGER INITIALS \_\_\_\_\_

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 \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 PRESENT ADDRESS \_\_\_\_\_ 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)
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

B. Do you have any unusual expenses related to employment, such as a care attendant or auxiliary apparatus for a 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 an accessible unit or reasonable accommodation due to disability? \_\_\_Yes \_\_\_No

**C. INCOME: LIST ALL SOURCES OF INCOME AS REQUESTED BELOW. ENTER ZERO (\$) 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	
_____		Tax Credit ANNUAL amount	\$ _____
_____	k.	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 \_\_\_\_\_ If yes, explain \_\_\_\_\_

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 \$ \_\_\_\_\_

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

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

**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:

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

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? \_\_\_\_\_

**CRIMINAL HISTORY:**

1. Are you a current illegal user of controlled substance or have you ever been convicted of using a controlled substance? \_\_\_Yes \_\_\_No. If yes, have you successfully completed a controlled substance abuse recovery program or are you presently enrolled in such a program? \_\_\_Yes \_\_\_No
2. Have you or any member of your household ever been convicted or pleaded "guilty" or "no contest" to a crime (whether or not resulting in a conviction)? \_\_\_Yes \_\_\_No  
If yes, what State/County? \_\_\_\_\_ When? \_\_\_\_\_
3. Are you or any member of your family a drug dealer or have you of any family member ever been a drug dealer? Yes \_\_\_ No \_\_\_
4. Have you or any household member 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? \_\_\_\_\_
5. Are you or any household member a Registered or Unregistered Sex Offender? \_\_\_Yes \_\_\_No  
If yes, list State(s): \_\_\_\_\_
6. Please list all States you have lived in: \_\_\_\_\_

**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

**ATTACHMENT:** Things You Should Know About USDA Rural Rental Housing

**\*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)

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

Gender:

- Male  Female

**APPLICANT #2**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #3**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #5**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #7**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #4**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #6**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**APPLICANT #8**

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race: (Mark one or more)

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

Gender:

- Male  Female

**Unlawful discrimination.** "This institution is an equal opportunity provider and employer. If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov)."