



Equal
Housing
Opportunity

<u>Office use only</u>
Date: _____
Time: _____
Apt. Size: _____
Recvd. By _____

<u>Office use only</u>
Gross Income: _____
Adj. Income: _____
V: _____ L: _____ M: _____

APPLICATION FOR OCCUPANCY

PLEASE PRINT

Return completed application to

____ MANZANITA HILLS APTS., 1526 SPRUCE STREET, ANDERSON, CA 96007 - Telephone (530) 365-4944

____ RIVER GARDENS APTS., 3195 BRIARWOOD DRIVE, ANDERSON, CA 96007 - Telephone (530) 365-4771

An applicant may be interviewed only after a completed Application is received. Completed Applications are processed in order of date and time received. You may contact the rental office for assistance in completing the Application. If more space is needed for the information required, please write on the back of the page.

A. GENERAL INFORMATION

Applicant Name(s): _____
 Current Address: _____ Tel.#: _____

List all persons who will live in the apartment. List head of household first.

Name	Relationship	Date of Birth	Social Security No.	Sex
1. _____	Head	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Is anyone in this household a full-time student? Yes _____ No _____ Name(s) _____

Marital status (check one): Married: _____ Separated: _____ Unmarried (Single, divorced, widowed): _____

B. REFERENCE INFORMATION

Current Landlord:
 Name: _____ Address: _____
 Telephone: _____ Dates lived there: _____ Reason for moving: _____

Previous Landlord(s):
 Name: _____ Address: _____
 Telephone: _____ Dates lived there: _____ Reason for moving: _____

Previous Landlord(s):
 Name: _____ Address: _____
 Telephone: _____ Dates lived there: _____ Reason for moving: _____

Non-related Personal References:

Name	Address	Telephone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Household Financial Obligations: (Include ALL medical expenses, car payments, child support, loans, etc.)

Name	Monthly Payment	Name	Monthly Payment
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

C. HOUSEHOLD INCOME – List any source of income that you or any household member anticipates receiving during the next twelve months (Mark Yes or No for each source, if yes, complete the blanks to the right).

Yes	No	Source of Income	By which Family Member	Source of Income (Name, Address, Phone #)	Monthly Gross
<input type="checkbox"/>	<input type="checkbox"/>	Wages	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	SSI Benefits	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	SSI Benefits	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Veterans Benefits	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement/Pension(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Comp.	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Workers Comp.	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	TANF	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alimony	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child Support	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Monetary Gift(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	School Grants/Scholarships	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Full Time Student Income	_____	_____	_____
		(Only Full time Students 18 & Over)			
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____	_____

Do you anticipate any changes in this income in the next 12 months or do you expect to receive any **lump sum** payment such as inheritances, lottery winnings, insurance settlements or an amount other than your monthly allotment from Social Security, TANF or Disability? Yes _____ No _____ If Yes, explain: _____

D. ASSETS

Yes	No	Name on Account	Account Number	Company or Bank Name and Address	Balance or Cash Value
<input type="checkbox"/>	<input type="checkbox"/>	Checking Account(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Savings Account(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Money Market Account(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trust Account(s)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Certificates of Deposit	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Safety Deposit Box	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	IRA/Keogh/Life Ins.	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Retirement Accts.	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stocks or Bonds	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Assets	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	IRA	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Savings Bond	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Whole Life Insurance Policy	_____	_____	_____

Real Property: Do you own any property? Yes _____ No _____ If Yes, state type of property _____
 Location: _____ Current Market Value: _____
 Outstanding Mortgage Balance: _____

Have you sold/disposed of any business, property or other assets in the last 2 years? Yes _____ No _____
 If Yes, state type of business, property or asset _____
 Date of Sale/Disposition _____ Market Value when Sold/Disposed of _____
 Amount Sold/Disposed for _____

Do you have any other assets not listed above (i.e. Recreation vehicle, boat, motorcycle; do not include personal property)?
 Yes _____ No _____ If Yes, please list _____

E. MEDICAL/DISABILITY ASSISTANCE EXPENSES

Medical Expenses: Complete this part ONLY if head of household or spouse is 62 or older or disabled.

Medicare Premiums Monthly Amount \$ _____
Medical Insurance Coverage Monthly Amount \$ _____
Do you anticipate having any medical expenses within the next twelve (12) months that are not paid by Medicare or Medical or an insurance policy? Yes _____ No _____
Anticipated Medical Expenses NOT covered by Insurance NOR reimbursed Monthly Amount \$ _____
Medical bills or outstanding costs on which you are making monthly payments Monthly Amount \$ _____
Medical related travel costs Monthly Amount \$ _____
Any other medical expenses: list type and amounts _____ Monthly Amount \$ _____
_____ Monthly Amount \$ _____

Disability Assistance Expenses: Complete this part ONLY for expenses to the extent needed to enable any family member to be employed.

Does your household have any disability or attendant care expenses? Yes _____ No _____
If yes, do you employ an attendant for a household member to work? Yes _____ No _____
If yes, Specialized Medical Attendant Care: state name of care giver & cost _____ \$ _____
Auxiliary Apparatus: list type and cost _____ \$ _____
_____ \$ _____
Are any of these expenses paid for or reimbursed by an outside agency? Yes _____ No _____
If Yes, enter name and address of agency: _____

F. CHILD CARE EXPENSES - Complete this part for household minors under 13 ONLY.

Do you pay for childcare expenses? Yes _____ No _____
Name(s) of children cared for: _____ Age _____
_____ Age _____
_____ Age _____
Name of person/agency caring for children: _____
Address: _____
Telephone: _____
Weekly cost of child care due to employment \$ _____ Weekly cost of child care due to education \$ _____

G. PROGRAM INFORMATION

What size of unit are you requesting? 1 Bedroom _____ 2 Bedroom _____
Do you wish to claim a \$400 deduction from your household income based on an "Elderly Household" status, where the tenant or co-tenant is 62 or older or disabled? Yes _____ No _____
Do you wish to have priority for an apartment with special design features for persons with disabilities?
Yes _____ No _____
Do you have a Letter of Priority issued by USDA-Rural Development due to displacement from another property?
Yes _____ No _____
Are you being or have you ever been evicted from any type of housing? Yes _____ No _____
Has your household's assistance or tenancy in a subsidized housing program ever been terminated for fraud, non-payment of rent or failure to cooperate with recertification procedures? Yes _____ No _____ If yes, describe the circumstances:

Have you ever been convicted of a felony? Yes _____ No _____
Are you currently a user of an illegal controlled substance? Yes _____ No _____
Have you ever been convicted of a drug violation (use, attempted use, possession, manufacture, sale, or distribution)?
Yes _____ No _____
Have you successfully completed a controlled substance abuse recovery program or presently enrolled in such a program?
Yes _____ No _____
Are you now or will you become a part-time or full time student prior to move-in? Yes _____ No _____
Have you been or do you plan to be a full-time student for at least five (5) calendar months (not necessarily consecutive) in the current calendar year? Yes _____ No _____
How did you hear about this housing? _____

H. OTHER INFORMATION

List all cars, trucks or other vehicles owned. (Parking will be provided for one vehicle unless approved by management.)

Type of Vehicle: _____ Year/Make/Model: _____ Color: _____
License Plate No. _____ Registered To: _____
Type of Vehicle: _____ Year/Make/Model: _____ Color: _____
License Plate No. _____ Registered To: _____

Do you own any pets? Yes _____ No _____ If yes, describe _____
Note: Pets are **not** allowed.

Do you have a Section 8 certificate? Yes _____ No _____

Amount of rent you are paying \$ _____

Are you currently living in a subsidized complex? Yes _____ No _____

Do you own or use a waterbed? Yes _____ No _____ Do you have waterbed insurance? Yes _____ No _____
If Yes, Name/address of insurance company _____

In case of emergency notify: _____
Address: _____

Telephone: (_____) _____

I. CERTIFICATION

I/We hereby certify that the unit applied for will be the household's permanent residence.

I/We further certify that I/we do/will not maintain a separate subsidized rental unit in another location.

I/We understand that I/we must pay a security deposit for this unit.

I/We understand that my/our eligibility for housing will be based on USDA-Rural Development income limits and tenant selection criteria.

I/We certify that I/we will keep management notified of any changes in your application. This includes a change in household size, current address, income or assets.

I/We certify that all information in this Application is true to the best of my/our knowledge and understand that false statements or information are punishable by law and will lead to cancellation of this Application or Termination of Tenancy after occupancy.

SIGNATURES:

Signature

Co- Signature

Date _____

Date _____

J. AUTHORIZATION/CONSENT

I/We do hereby authorize **Manzanita Hills Apartments** and/or **River Gardens Apartments** and its staff or authorized representative to contact any agencies, law enforcement offices, companies, groups or organizations to verify any information contained in this Application or to obtain and verify any additional information or materials which are deemed necessary to complete my/our Application for housing in programs administered by **USDA Rural Development**.

Further, I/we consent to the release of wage matching data to the RHS and the borrower.

SIGNATURES:

Signature

Co- Signature

Date _____

Date _____

“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 Service that the Federal laws prohibiting discrimination against tenant applicants 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.”

The following is to be collected from the Applicant (Head of Household)

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Race: (Mark one or more)

1. American Indian/Alaskan Native _____ 2. Asian _____ 3. Black or African American _____

4. Native Hawaiian or Other Pacific Islander _____ 5. White _____

Gender:

Male _____ Female _____