



27. List Sources of Income

Monthly

Annually

- a. SOCIAL SECURITY..... \_\_\_\_\_
- b. PENSIONS ..... \_\_\_\_\_
- c. REPARATIONS ..... \_\_\_\_\_
- d. SALARY ..... \_\_\_\_\_
- e. RENTALS ..... \_\_\_\_\_
- f. INTEREST ON BANK ACCOUNTS & STOCKS..... \_\_\_\_\_
- g. OTHER \_\_\_\_\_

28. Bank Accounts with Bank Address:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

29. Are there other sources of payment of rental (give nature and amount)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

30. Do you have hospitalization insurance? (specify):

- a. BLUE CROSS/BLUE SHIELD OF N.J. # \_\_\_\_\_
- b. BLUE CROSS/BLUE SHIELD OF N.Y. # \_\_\_\_\_
- c. MEDICARE # \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

32. Name and Address of Your Physician \_\_\_\_\_

33. Names and Addresses of Children, Involved Relatives or Authorized Agents:

NAME	COMPLETE ADDRESS INCLUDING ZIP	TELEPHONE (HOME)	OCCUPATION TELEPHONE (BUSINESS)
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I hereby certify that the foregoing information is true and complete to the best of my knowledge and inquiries may be made to verify the statements made herein.

\_\_\_\_\_  
DATE SIGNATURE OF APPLICANT(S)

# FINANCIAL RESOURCE DATA

**APPLICANT'S NAME** \_\_\_\_\_

**MONTHLY INCOME**

SOCIAL SECURITY \$ \_\_\_\_\_  
PRIVATE PENSION \$ \_\_\_\_\_  
ANNUITIES \$ \_\_\_\_\_  
DISABILITY INSURANCE \$ \_\_\_\_\_  
INTEREST \$ \_\_\_\_\_  
DIVIDENDS \$ \_\_\_\_\_  
TRUST INCOME \$ \_\_\_\_\_  
OTHER \$ \_\_\_\_\_  
PLEASE SPECIFY \$ \_\_\_\_\_

**TOTAL MONTHLY INCOME** \$ \_\_\_\_\_

**ASSETS**

	<b>VALUE</b>	<b>INCOME</b>
CHECKING ACCOUNT	\$ _____	\$ _____
SAVINGS ACCOUNT	\$ _____	\$ _____
MONEY MARKET	\$ _____	\$ _____
STOCKS AND BONDS	\$ _____	\$ _____
FUNDS OR PROPERTY IN TRUST	\$ _____	\$ _____
VALUE OF HOME YOU OWN	\$ _____	\$ _____
VALUE OF OTHER REAL ESTATE	\$ _____	\$ _____
OTHER (PLEASE SPECIFY)	\$ _____	\$ _____

**TOTAL ASSETS** \$ \_\_\_\_\_ **TOTAL INCOME** \$ \_\_\_\_\_

Have you or any members of your household disposed of assets for less than fair market value during the past two years?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, describe the assets you disposed of:

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

**MEDICAL ALLOWANCES:**

AMOUNT SUBTRACTED FOR MEDICARE \$ \_\_\_\_\_  
ANTICIPATED EXPENSES FOR PRESCRIPTIONS \$ \_\_\_\_\_  
MEDICAL INSURANCE \$ \_\_\_\_\_  
ANTICIPATED EXPENSES FOR DOCTORS, DENTISTS, ONGOING TREATMENTS \$ \_\_\_\_\_  
HOME HEALTH AIDES \$ \_\_\_\_\_  
MISCELLANEOUS MEDICAL EXPENSES \$ \_\_\_\_\_

**PLEASE PROVIDE VERIFICATION OF ALL INCOME AND EXPENSES**

**HUD REGULATIONS STATE THAT ALL INCOME AND EXPENSES  
MUST BE VERIFIED IN ORDER TO BE ACCEPTED.  
FINANCIAL INFORMATION WITHOUT PROOF CAN NOT BE ACCEPTED.**

**CERTIFICATION FOR QUALIFIED LONG-TERM CARE INSURANCE EXPENSES**

I certify that the long-term care insurance policy for which I pay premiums

(insert policy provider name) \_\_\_\_\_,

policy number \_\_\_\_\_ meets the following conditions.

- 1) It is guaranteed renewable;
- 2) It does not provide a cash surrender value which can be paid, assigned, pledged, or borrowed;
- 3) It provides that refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits; and
- 4) It does not pay or reimburse expenses for services or items that would be reimbursed under Medicare (except where Medicare is a secondary payer or the contract makes per diem or other periodic payments without regard to expenses.)

\_\_\_\_\_  
Name(print)

\_\_\_\_\_  
Name(sign)

\_\_\_\_\_  
Unit Number

# **Application checklist**

**\*\*\*THIS SHEET MUST BE SIGNED AND RETURNED WITH ALL NECESSARY DOCUMENTS.**

**\*\*Copies of The following items must be included with your application.**

\*Please check off each item if applicable and sign checklist on the bottom.

## **TENANT APPLICATION**

**PROOF OF AGE** (Birth Certificate)

**CIVIL RIGHTS DOCUMENT**

**FINANCIAL DOCUMENTS**

**SOCIAL SECURITY CARD**

**MEDICARE CARD**

**SECONDARY INSURANCE CARD**

Are you an American citizen?  yes  no If no, please provide copy of alien registration card

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## **INCOME**

**\*FULL AMOUNT OF PERIODIC AMOUNTS RECEIVED FROM SOCIAL SECURITY, ANNUITIES, INSURANCE POLICIES, RETIREMENT FUNDS, PENSIONS AND WELFARE ASSISTANCE.**

SOCIAL SECURITY AWARD LETTER

PENSION STATEMENT

ANNUITY, INSURANCE,

**REPARATION PAYMENTS PAID BY FOREIGN GOVERNMENT (GERMAN-JAPANESE) ARE EXCLUDED FROM INCOME.**

**\*INTEREST, DIVIDENDS, OTHER NET INCOME FROM REAL OR PERSONAL PROPERTY**

**\*ASSETS INCLUDE THE FOLLOWING: CASH HELD IN CHECKING, SAVINGS, SAFE DEPOSIT BOXES; REVOCABLE TRUSTS; STOCKS, BONDS, TREASURY BILLS, CD'S, MUTUAL FUNDS, MONEY MARKET ACCOUNTS, IRA'S, 401K'S**

MOST RECENT BANK ACCOUNT STATEMENTS

REAL ESTATE ASSESSMENT

BROKERAGE STATEMENTS

ALIMONY PAYMENTS

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## **DEDUCTIBLE MEDICAL EXPENSES (OUT OF POCKET-NON-REIMBURSABLE)**

**\*THE FOLLOWING ARE EXAMPLES OF ELIGIBLE ITEMS FOR MEDICAL EXPENSE DEDUCTIONS.**

SERVICES OF RECOGNIZED HEALTH CARE PROFESSIONALS

SERVICES OF HEALTH CARE FACILITIES, LABORATORY FEES, ETC.

MEDICAL INSURANCE PREMIUMS

PRESCRIPTION AND CERTAIN NON-PRESCRIPTION MEDICINES

DENTAL BILLS

EYEGASSES, CONTACT LENSES

HEARING AID AND BATTERIES

LIFELINE

PAYMENTS ON ACCUMULATED MEDICAL BILLS

ASSISTIVE DEVICES- CANES, WALKERS, WHEELCHAIRS

NUTRITIONAL SUPPLEMENTS ORDERED BY A PHYSICIAN ONLY

ATTENDANT CARE OR PERIODIC MEDICAL CARE

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**\*SIGNATURE OF APPLICANT OR AUTHORIZED FAMILY MEMBER**