Date Received/Time

SOURCE OF INQUIRY:

NEWSPAPER _____

OTHER _____

MIRIAM APARTMENTS

DAUGHTERS OF MIRIAM CENTER/THE GALLEN INSTITUTE

135 HAZEL STREET

CLIFTON, NEW JERSEY 07011

TENANT APPLICATION

1. Name _____ Male ❑ Female ❑
   LAST FIRST MAIDEN
2. Present Address _____
   ZIP COUNTY
3. Phone No. _____ 4. Social Security No. _____
5. Medicare No. _____ 6. Medicaid No. _____
7. Date of Birth or Estimated Age _____ 8. Email _____
9. Are you: Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑
10. Please describe the race, color or national origin of Head of Household/family members:

    White ❑ African-American ❑ Hispanic ❑ Native American ❑ Asian ❑ Other ❑ Decline to Answer ❑

— IF TWO PEOPLE ARE APPLYING, COMPLETE THIS SECTION —

11. Name _____ Male ❑ Female ❑
    LAST FIRST MAIDEN
12. Present Address _____
    ZIP COUNTY
13. Phone No. _____ 14. Social Security No. _____
15. Medicare No. _____ 16. Medicaid No. _____
17. Relationship to First Applicant _____
18. Date of Birth or Estimated Age _____ 19. Email _____
20. Relationship Status: Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑
21. Do you live: Alone ❑ With Relatives ❑ Other _____
22. Do you reside in: House ❑ Apartment ❑ Boarding House ❑ Rooming House ❑
23. How much rent do you pay? $ _____
24. Do you as head of household, or does any member of your family require a reasonable accomodation such as a handicap accessible unit, parking space, or an assistance animal? Yes ❑ No ❑
25. Are you employed? Yes ❑ No ❑ Full Time ❑ Part Time ❑
26. Type of Employment _____
27. Name of Employer _____
28. Are you Self Employed? Yes ❑ No ❑ Nature of Business _____
29. If you are not now employed, what was your last employment? _____
30. Last Year of Employment _____

31. 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 _____		

32. Bank Accounts with Bank Address:

a. _____

b. _____

c. _____

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

a. _____

b. _____

c. _____

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

Name _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Office Phone _____

Name _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Office Phone _____

Name _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Office Phone _____

Name _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ OfficePhone _____

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)

Daughters of Miriam Center/The Gallen Institute does not discriminate against any person due to race, color, religion, sex, handicap, familial status or national origin.

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	**VALUE**	**INCOME**
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.

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 Amercian 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

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
_____ EYEGLASSES, 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

_____

*SIGNATURE OF APPLICANT OR AUTHORIZED FAMILY MEMBER