



APPLICATION FOR RESIDENCY

PLEASE PRINT

Please complete this form and return it to the manager, at the address listed above. It must be filled out completely in order for us to consider you for occupancy, items that do not apply must show a dash or N/A answer. Completed applications are placed in order of date and time received.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at <http://www.ascr.usda.gov/> and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Applicant will be notified in writing of waiting list status within 10 days.

A. GENERAL INFORMATION

Applicant _____ Co-applicant _____

Current Address _____

City _____ State _____ Zip _____

Dates Of Occupancy _____ To _____ Applicant's Phone _____

Applicant's Current Email Address: _____

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

NAME _____ RELATIONSHIP **Head** BIRTH DATE _____ SOC. SEC. # _____

NAME _____ RELATIONSHIP _____ BIRTH DATE _____ SOC. SEC. # _____

NAME _____ RELATIONSHIP _____ BIRTH DATE _____ SOC. SEC. # _____

NAME _____ RELATIONSHIP _____ BIRTH DATE _____ SOC. SEC. # _____

Is anyone in this household a full time college student? _____ Yes _____ No

Name(s)

B. INCOME: List all sources of income requested below:

Family member Name:

Source of Income

_____ A.	Social Security	Monthly Amount\$ _____
_____	Social Security	Monthly Amount\$ _____
_____ B.	Pensions	Monthly Amount \$ _____
_____	Pensions	Monthly Amount \$ _____
	Source of Pensions: _____	
_____ C.	Veterans Benefits	Monthly Amount\$ _____
	Claim # _____	
_____ D.	SSI Benefits	Monthly Amount\$ _____
_____	SSI Benefits	Monthly Amount \$ _____
_____ E.	Unemployment Com	Monthly Amount\$ _____
_____	Unemployment Com	Monthly Amount\$ _____
_____ F.	AFDC	Monthly Amount\$ _____
_____ G.	Wages, Salaries, etc. Gross	Monthly Amount\$ _____
	Employer _____	
	Position Held _____	How Long Employed _____
_____	Wages, Salaries, etc. Gross	Monthly Amount\$ _____
	Employer _____	
	Position Held _____	How Long Employed _____
_____ H.	Full Time Student Income	Monthly Amount\$ _____
	(only full time students 18 & over)	
_____	Full Time Student Income	Monthly Amount\$ _____
	(only full time students 18 & over)	
_____ I.	Alimony	Monthly Amount\$ _____
	Source _____	
_____ J.	Child Support	Monthly Amount\$ _____
	Source _____	
_____ K.	Interest Income	Monthly Amount\$ _____
	Source _____	
_____	Interest Income	Monthly Amount\$ _____
	Source _____	
_____ L.	Other Income	Monthly Amount\$ _____
	Source _____	

TOTAL MONTHLY INCOME \$ _____

X 12

TOTAL GROSS ANNUAL INCOME \$ _____

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

IF YES, Explain: _____

C. ASSETS:

Checking Account(s)

_____ Bank _____ Balance \$ _____

_____ Bank _____ Balance \$ _____

Savings Account(s)

_____ Bank _____ Balance \$ _____

_____ Bank _____ Balance \$ _____

Trust Accounts

_____ Bank _____ Balance \$ _____

Certificates

_____ Bank _____ Balance \$ _____

_____ Bank _____ Balance \$ _____

Credit Union

_____ Bank _____ Balance \$ _____

_____ Bank _____ Balance \$ _____

Savings Bonds

_____ Maturity Date _____ Value \$ _____

_____ Maturity Date _____ Value \$ _____

Whole Life Insurance

Policy # _____ Face Value \$ _____

Cash Value of Life Insurance Policy \$ _____

Real Property: Do you own any property? Yes ____ No ____

If YES, Type of property _____

Location _____

Appraised Market Value \$ _____

Mortgage or Outstanding Loans Balance Due \$ _____

Amount of Annual Insurance Premium \$ _____

Amount of Most Recent Tax Bill \$ _____

Have you sold or disposed of any property in the last 2 years? Yes ____ No ____

If YES, Type of property _____

Market Value When Sold/Disposed \$ _____

Amount Sold/Disposed For \$ _____

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 \$ _____

Cash on hand \$ _____

Do you have any other assets not listed above (Excluding Personal Property)? Yes ____ No ____

If YES, List _____

D. MEDICAL/CHILD CARE/HANDICAP ASSISTANCE EXPENSES

MEDICAL COSTS: Complete this part ONLY if Head or Spouse is 62 or Older, Disabled or Handicapped.

1. Medicare Premiums Monthly Amount \$ _____
2. Medical Insurance Coverage Monthly Amount \$ _____
Name of Insurance Company _____
Address _____
3. Anticipated Medical/Drug/Prescription/Non Prescription costs NOT covered by insurance
NOR reimbursed: Monthly Amount \$ _____
4. Medical Bills or Outstanding Costs you are making monthly payments for:
Balance Due \$ _____ Monthly Amount \$ _____
Payable To: _____
5. Medical Related Travel Costs Monthly Amount \$ _____
6. Are you seeing a physician regularly? Yes___ No___
Name of Physician _____
Address _____
Projected costs NOT covered by insurance NOR reimbursed for the next 12 months \$ _____
Any Other Medical Expenses:
Type _____ Monthly Amount \$ _____
Type _____ Monthly Amount \$ _____

CHILD CARE COSTS: Complete ONLY for Children 12 & Younger.

7. Name(s) of children cared for:

_____ Age _____
Age _____
Age _____

Name & Address of person OR agency caring for children:

-
-
8. Weekly cost for child care due to employment \$ _____
 9. Weekly cost for child care due to education \$ _____

HANDICAP ASSISTANCE EXPENSES: Attendant care and/or apparatus expense that enables handicapped applicants or others in the household to work. Complete ONLY if Handicap Expenses allow someone in the household to work.

10. Type of Expense _____ To whom _____ Weekly Amount \$ _____
Type of Expense _____ To whom _____ Weekly Amount \$ _____
Type of Expense _____ To whom _____ Weekly Amount \$ _____

E. PROGRAM INFORMATION

1. Do you hold a letter of Priority Entitlement issued by USDA Rural Development? Yes ____ No ____
2. Are Currently Displaced due to your housing being rendered uninhabitable or being seized by legal action (for other than illegal activities.) Yes ____ No ____
If Yes, Describe _____
3. Are You Applying for status as an "Elderly Household", where the tenant or co-tenant is **62** or older, handicapped or disabled as defined by Rural Development? Yes ____ No ____
If so, do you realize you will be eligible for a \$400 and a medical deduction?
Please realize that your eligibility must be verified.
4. Would you or anyone in your household benefit from a wheelchair or other handicapped accessible unit? Yes ____ No ____
5. If so, would you like to request an adapted unit? Yes ____ No ____
6. Are you currently living in subsidized housing? Yes ____ No ____
7. Have you ever resided in a project financed and/or subsidized by the Government? Yes ____ No ____
If YES, Name & Address _____
8. Have you ever been evicted from housing? Yes ____ No ____
9. Have you ever been convicted of a felony? Yes ____ No ____
10. Are you currently using illegal drugs? Yes ____ No ____
11. Have you ever been convicted of sale, distribution, or possession of Illegal drugs? Yes ____ No ____
12. Are you now or will you become a part time or full time student prior to Move-in? Yes ____ No ____
13. How did you hear about this housing? _____
14. Would you rent an apartment for the full market rent of \$425.00 to \$604.00 for a one-bedroom or \$535.00 to \$702.00 for a two-bedroom until a subsidy becomes available? Yes ____ No ____
Briefly describe your reasons for applying. _____

F. REFERENCE INFORMATION

Please list **all** addresses in the last 5 years for all persons over 18 years of age (you must account for all five of the past years.)

Current Address: _____ City _____ State ____ Zip _____
Name of Complex/Manager/Owner _____
Home Phone _____ Business Phone _____
Dates of Occupancy _____ From _____ To _____

Previous Address: _____ City _____ State ____ Zip _____
Name of Complex/Manager/Owner _____
Home Phone _____ Business Phone _____
Dates of Occupancy _____ From _____ To _____

Previous Address: _____ City _____ State ____ Zip _____
Name of Complex/Manager/Owner _____
Home Phone _____ Business Phone _____
Dates of Occupancy _____ From _____ To _____

Previous Address: _____ City _____ State ____ Zip _____
Name of Complex/Manager/Owner _____
Home Phone _____ Business Phone _____
Dates of Occupancy _____ From _____ To _____

Previous Address: _____ City _____ State _____ Zip _____
Name of Complex/Manager/Owner _____
Home Phone _____ Business Phone _____
Dates of Occupancy _____ From _____ To _____

OTHER REQUESTED INFORMATION

VEHICLES: List any cars, trucks or other vehicles owned. (Parking will be provided for two vehicles on site.)

Make _____ Model _____ Year _____ Color _____

License Plate # _____ Person who's name car is registered in _____

Make _____ Model _____ Year _____ Color _____

License Plate # _____ Person who's name car is registered in _____

PETS: Do you own any pets? Yes ___ No ___

If YES, Describe _____

FAMILY HOUSEHOLD COMPOSITION:

The information regarding race, national origin, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the Rural Development, that Federal Laws prohibiting discrimination against tenant applicants on the basis of race, color, national origin, religion, sex, familial status, age and handicap 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 or authorized representative is required to note the race/national origin and sex of individual applicants on the basis of visual observation or surname.

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 Pacific Islander _____ 5 White _____

Gender: Male _____ Female _____

CERTIFICATION

I/We certify that if I/We rent an apartment in this complex, I/We will maintain it as my/our permanent residence and will not maintain a separate subsidized rental unit in a different location. I/We understand that I/We must pay a security deposit for this apartment. I/We understand that my/our eligibility for housing will be based on USDA Rural Development income limits and by Fountain View Apartments selection criteria. I/We declare the foregoing to be true to the best of my/our knowledge under penalty of perjury. I/We agree that the owner may cancel this application and terminate any agreement entered into in reliance on any misstatement made above.

SIGNATURE:

TENANT: _____

DATED: _____

CO-TENANT: _____

DATED: _____

AUTHORIZATION

I/We Do Hereby Authorize the Fountain View Apartments and its staff or authorized representative to contact any agencies, local police departments, offices, groups or organizations, to obtain and verify any information or materials which are deemed necessary to complete my/our application for housing in the program administered by Rural Development. I/We Further Authorize the Fountain View Apartments to verify all information listed on this application.

SIGNATURE:

TENANT: _____

DATED: _____

CO-TENANT: _____

DATED: _____

AUTHORIZATION TO RELEASE OF INFORMATION

I Authorize the State of Colorado, Department of Labor, to release to:

USDA-Rural Development

State Director

Rural Housing Service

655 Parfet. Rm E-100

Lakewood, CO 80215

Information from my wages or unemployment insurance records on file with the State of Colorado, Department of Labor. I understand that this authorization will be in effect for as long as I have a Rural Development loan and/or application, am a tenant residing in the project named below, and/or the term of assistance received from USDA, Rural Housing Services.

Applicant Name (Please type or Print)

Social Security Number

Signature

Date

CO-Applicant Name (Please type or Print)

Social Security Number

Signature

Date