SHAKESPEARE SENIOR HOUSING

Also known as, the Antonia Diaz Apartments

TENANT APPLICATION
US HUD SECTION 202 SUPPORTED HOUSING FOR THE ELDERLY
at Shakespeare Senior Apartments

MAIL **ONLY ONE (1) APPLICATION FORM PER FAMILY BY REGULAR MAIL.**
(DO NOT SEND BY REGISTERED, EXPRESS OR CERTIFIED MAIL.)
DO NOT MAIL MORE THAN ONE APPLICATION PER FAMILY. IF MORE THAN ONE IS RECEIVED, THE FAMILY WILL BE DROPPED TO THE BOTTOM OF THE LIST.

MAIL TO: **Shakespeare Senior HDFC**
1465 Nelson Avenue, Suite A
Bronx, New York 10452

APPLICATIONS MUST BE RECEIVED BY March 17, 2014.

Each application received will be recorded in a log in the order selected by random lottery. Since so many elderly need housing this development will not be able to accommodate all who are eligible. As applicants can be reached on our waiting list log, they will be called in for an interview and to provide additional information.

NO PAYMENT OR FEE SHOULD BE GIVEN TO ANYONE IN CONNECTION WITH THE PREPARATION, FILING OR PROCESSING OF THIS APPLICATION FOR SUBSIDIZED HOUSING.

Please note: All apartments in this project have one bedroom; not more than two (2) persons may occupy an apartment in this building. At least one member of the household must be no less than 62 years of age at the time of application.

---

1. THIS INFORMATION IS TO BE FILLED OUT BY THE APPLICANT:

Name _____ Age _____

Street Address _____ Apt. No._____

City _____ State _____ Zip _____

Home Phone No. ( )_____ Work Phone No. ( )_____

Social Security Number _____ Date of Birth _____

2. FUNCTIONAL STATUS:

Are you or your spouse disabled? Yes _____ No _____
If "yes", enter name of disabled individual(s) here _____

What is the disability? _____

Shakespeare Senior HDFC does not discriminate on the basis of disability status in the admission or access to or occupancy or employment in its federally assisted programs and activities.

Are you or your spouse handicapped to the degree that you require assistance? (Please check applicable aid.)
Wheelchair _____ Walker _____ Crutches _____
Metal braces _____ Cane _____ Other Mechanical Aid _____

If "yes" enter nature of assistance needed: _____

Do you or your spouse need assistance in any of the following daily living activities?
Please indicate if the need is for you or your spouse by checking self or spouse next to each item:

Eating	Self _____	Spouse _____
Bathing	Self _____	Spouse _____
Grooming	Self _____	Spouse _____
Dressing	Self _____	Spouse _____
Home Management	Self _____	Spouse _____

Is your current residence designed for the handicapped? Yes _____ No _____

3. RENT: What is your present rent? _____

What is your actual average monthly utilities for the past 12 months $ _____

Check here the utilities paid by you monthly and indicate the average monthly amount:

___Gas $ _____; ___ Electric $ _____; ____ Heat $ _____; ____Water $ _____.

4. PROJECT BASED OR TENANT BASED SUBSIDY:

Do you live in Public Housing, State Housing, or Federal Housing and/or receive the benefit of a monthly Housing Assistance Payment or Section 8? Yes _____ No _____

If "yes", enter the:

Name of project _____

Address of project _____

Telephone # of Project Manager _____

Have you been subsidized through a housing subsidy program in the past? Yes _____ No _____
If "yes", enter the:

Name of project _____

Address of project _____

Telephone # of Project Manager _____

5. <u>FAMILY COMPOSITION</u>:

How many persons in your household? _____ How many bedrooms do you have? _____

List all persons who will live with you:

NOTE: A MAXIMUM OF TWO (2) PERSONS MAY OCCUPY A ONE BEDROOM APARTMENT IN THIS BUILDING.

Full Name	Relationship	Birthdate	Age	Sex M/F	Check if Attending School	Occupation	Social Security Number
	Self						

Do you anticipate any additions to your household in the next twelve months? Yes ____ No____

If "yes", please explain _____

_____

_____

6. <u>INCOME</u>:

List all full, part-time and seasonal employment for all household members. Include self-employed earnings:

<u>House Member</u>	Name and Address of Employer	<u>GROSS EARNINGS</u>
<u>Self</u> _____	_____	$_____per _____
_____	_____	$_____per _____

7. OTHER SOURCES OF INCOME: (Examples: Public Assistance (welfare), social security, SSI, pension, veteran's benefits, disability compensation, unemployment compensation, interest income, baby-sitting, sales of products or goods or services, caretaking, alimony, child support, annuities, dividends, Income from rental property, Armed Forces Reserves, scholarships, and/or grants and any other income.)

HOUSEHOLD MEMBER	TYPE OF INCOME	GROSS EARNINGS
Self	_____	$_____ per _____
_____	_____	$_____ per _____

Do you anticipate any changes in this income in the next twelve (12) months?
Yes_____ No _____

If yes, explain _____

_____

_____

8. **CURRENT ASSETS:** *For All members of the household.*

Checking Accounts:

Name on the account _____

Bank _____ Acct. No. _____ Amount _____

Name on the account _____

Bank _____ Acct. No. _____ Amount _____

Savings Accounts:

Name on the account _____

Bank _____ Acct. No. _____ Amount _____

Name on the account _____

Bank _____ Acct. No. _____ Amount _____

Stocks, Bonds and Mutual Funds: Value $ _____ US Savings Bonds: Value $ _____

Do you now own Real Estate? Yes ____ No ____ If "yes" what is the value? $ _____

Do you own a Co-op and/or Condo? Location:_____
Number of Bedrooms:_____ Purchase Price: _____

Other Current Assets	TYPE	VALUE/AMOUNT
	_____	_____
	_____	_____
	_____	_____

Assets Recently Disposed Of:

Has any family member disposed of any assets (for example, a house, a car, a co-op or condo) during the past two years from the date of this application? Yes _____ No _____

If "yes", provide the following information:

Asset	Date Acquired	Price Paid	Date of Disposition	Amount Received
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were there any penalties, broker/legal fees or settlement cost in connection with the recent disposition of assets?
Yes _____ No _____ If "yes", Amount $ _____ Please provide details on an attached page.

9. MEDICAL EXPENSES:

This allowance is permitted ONLY for households whose HEAD or SPOUSE is age 62 or older, Handicapped, or Disabled. Consider ONLY medical expenses that will not be paid by an outside source (e.g., Insurance, Medicare, Medicaid or grants by a State agency or charitable organization.)

Please list all health care insurance you and your spouse have and indicate which is for self or spouse:

Medicare	Self_____	Spouse_____
Medicaid	Self_____	Spouse_____
Other (Specify:)	Self_____	Spouse_____

What are the medical expenses anticipated to be paid by your household in the next 12 month period?
$ _____

10. HANDICAP EXPENSES:

This allowance applies ONLY if a family member is Handicapped or Disabled. Consider ONLY handicap expenses that will not be paid or reimbursed by an outside source such as Insurance, Medicaid or grants by a State agency or charitable organization; and NOT paid to a family member living in the household.

What are the handicap expenses **anticipated** to be paid by the household in the next 12 month period?
$ _____
Will these expenses enable an adult member of the household to work? Yes _____ No _____

11.ADDITIONAL INFORMATION:

Will this apartment be your primary residence? Yes ____ No____
If "no", explain_____

How did you hear about this Development?
Sign posted on building _____ Newspaper _____ Local Organization or Church _____

Friend or Family _____ Assisted Housing List _____ Brochure/Pamphlet _____

Other _____ (example; Fair Housing Counseling Center, Mayor's Office of the Handicapped, etc.)

I DECLARE THAT THE STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

WARNING: WILLFUL FALSE STATEMENTS OR MISREPRESENTATION ARE A CRIMINAL OFFENSE UNDER SECTION 1001 OF TITLE 18 OF THE U.S. CODE.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____

PLEASE DO NOT MAIL MORE THAN ONE APPLICATION PER FAMILY, PER DEVELOPMENT, IF MORE THAN ONE APPLICATION IS RECEIVED, ALL APPLICATIONS SUBMITTED BY THE FAMILY WILL BE PLACED TO THE BOTTOM OF THE LIST.

The following information is required for statistical purposes so that the Department of HUD may determine the degree to which its programs are utilized. This information MUST be completed. It will not affect the processing of this application.

RACIAL GROUP IDENTIFICATION (used for statistical purpose ONLY). Please check one group which identifies the HEAD OF THE HOUSEHOLD.

White (Non-Hispanic Origin) _____ Black (Non-Hispanic Origin) _____

American Indian or Alaskan Native _____ Hispanic _____

Asian or Pacific Islander _____ Other (Specify) _____