



Approximate move in date: \_\_\_\_\_

# WESLEY HOMES, INC. ASBURY HARRIS EPWORTH TOWERS

**1. APPLICANT(S):**

**PLEASE PRINT**

**Head of Household:**

\_\_\_\_\_

<b>First</b>	<b>Middle Initial</b>	<b>Last</b>
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**Current Mailing Address:**

\_\_\_\_\_

Street	Apt.
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\_\_\_\_\_

<b>City</b>	<b>State</b>	<b>Zip Code</b>
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Telephone:

\_\_\_\_\_

(Area Code)

**Co-Head Name:**

\_\_\_\_\_

<b>First</b>	<b>Middle Initial</b>	<b>Last</b>
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**Current Mailing Address:**

\_\_\_\_\_

Street	Apt.
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\_\_\_\_\_

<b>City</b>	<b>State</b>	<b>Zip Code</b>
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Telephone:

\_\_\_\_\_

(Area Code)

**2. Household Composition and Characteristics**

(List the head of the household and all other members who will be living in the unit. Give the relationship of each family member to the head. **Head of household MUST be 62 years or older**)

Member's Full Name	Relationship	Birth Date	Sex M or F	Social Security Number
	Head			
	Spouse/Co Head			

Marital Status of the Head of Household:  Single  Married  Separated  
 Divorced  Widowed

**Office Use Only:**  *EL Income*  *Very Low Income*  *Low Income*  
**Date Received:** \_\_\_\_\_ **Time:** \_\_\_\_\_

3. **Race or Ethnicity of Household** (Complete attached Race and Ethnic Data Reporting Form for each member of household)
4. **Are you, or a member of your household, a student enrolled in an Institute of Higher Education as defined by the Higher Education Act of 1965 – Amended 1998?**

YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, are you \_\_\_\_\_ Full-Time \_\_\_\_\_ Part-Time

**FOR ELIGIBILITY, ALLOWANCE AND ACCOMMODATION PURPOSES ONLY**

5. **Previous Housing History (For Asbury Harris Epworth Towers Screening Criteria)**

**Current residence:**

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ How long have you lived there? \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_  
 Are you renting: \_\_\_ Yes \_\_\_ No. If yes, please provide the following:  
 Landlord/Manager Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Former Residence:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ How long did you live there? \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_  
 Are you renting: \_\_\_ Yes \_\_\_ No. If yes, please provide the following:  
 Landlord/Manager Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Former Residence:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ How long did you live there? \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_  
 Are you renting: \_\_\_ Yes \_\_\_ No. If yes, please provide the following:  
 Landlord/Manager Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

***You must report ALL states you have resided in since the age of 18, and the last address in each state, up to the above addresses, in which you resided during the past five years. All applicants over 18 are required to report this information.***

State	From (date)	To (date)	Last Street Address in that state	City	County

## EMERGENCY CONTACT

6. In case of an emergency, whom would we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name and address of nearest relative NOT living with you

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name and address of person to be contacted if you become incapacitated.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

7. Personal References (For Asbury Harris Epworth Towers Screening Criteria)

Please provide the name, address and phone number of three personal references other than family or relatives.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

8. **Employment** Are you/household members currently employed? \_\_\_ Yes \_\_\_ No

If yes, give name and address of your employer(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

(Area Code)

## 9. Income and Asset Information

### Income

Do you or any members of your household receive any of the following types of income on a regular basis?

	Source	Monthly Amount	Documentation Needed
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wages/Salaries		Pay stub/letter from employer & provide <b>Provide Name/address</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security /SSI Railroad Retirement		Current Award Letter
<input type="checkbox"/> Yes <input type="checkbox"/> No	Private Pensions		Most Recent Statement/Check Stub & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Annuities		Most Recent Statement/Check Stub & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Disability Insurance		Most Recent Statement/Check Stub & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Interest from Investments		Bank Statement; Forms 1099 & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dividends		Dividend Statement & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trust Income		Last 6 months statements & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Income from Self-Employment		Tax Documents or Written Statement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)		Written Documentation

*If further space is needed to provide information on sources of income, please attach a separate sheet describing such sources of income.*

Do you or any members of your family have any regular sources of income not listed above?

Yes     No    If yes, please describe \_\_\_\_\_

**10. Assets**

Do you or any members of your family have any of the following assets?

	<b>Asset</b>	<b>Current Value</b>	<b>Documentation Needed</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cash on Hand		Signed Statement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Checking Account(s)		Copy of Most Recent Bank Statements (Last 6 months) and provide: <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Savings/Money Market Account(s)		Most Recent Statements (Last 6 months) and provide: <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks and Bonds		Most Recent Statement & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Certificate of Deposit		Copy of Certificate & provide <b>Institution Name/address/account no.</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Collectibles held for Investment		Current Appraisal

*If further space is needed to provide information on additional assets, please attach a separate sheet describing such assets.*

**Do you or any members of your household own a home, commercial property, or other real estate?**  Yes  No *If yes, please list.*

Address \_\_\_\_\_ Estimated Value  
 \_\_\_\_\_ \$ \_\_\_\_\_

**11. Do you or any members of your household have any life insurance policies with permanent cash value?** (May be called “whole life,” universal,” or “paid up” coverage.)  
 Yes  No *If yes, please list policies below:*

<b>Name AND address of Company(s)</b>	<b>Policy #</b>	<b>Face Value</b>	<b>Current Cash Value</b>

**12. Medical/Medical Expenses**

Do you have **Medicare**? \_\_\_ Yes \_\_\_ No If Yes, what is your premium amount? \_\_\_\_\_

Do you have **other medical insurance**? \_\_\_\_\_ If Yes, give the name of the insurance company, address, your policy number and the premium amount:

Are your medical bills paid by insurance? \_\_\_ Yes \_\_\_ No

Are you receiving medical assistance through Welfare? \_\_\_\_\_

**If you pay any portion of your medical and/or drug costs, please furnish us with an anticipated cost for the upcoming twelve (12) month period.**

Do you have any outstanding medical bills? \_\_\_ Yes \_\_\_ No If yes, list them below.

What medical expense do you expect to incur in the next twelve months that will not be covered by insurance? Examples include eyeglasses, hearing aid batteries, transportation to medical treatment.

List the names and addresses of the pharmacies that you use.

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Do you have prescription or non-prescription costs that are not covered by insurance? If yes, indicate below. *(If further space is needed, please attach a separate sheet and/or pharmacy printout)*

ITEM	MONTHLY COST	PRESCRIPTION	NON PRESCRIPTION

13. Do you have any **dependents** that live with you?  
\_\_\_ Yes \_\_\_ No

14. Have you or any members of your household **disposed of assets** for less than fair market value during the past two years? \_\_\_ Yes \_\_\_ No If yes, please describe:  
*(Complete attached Disposal of Assets Form)*

ASSET	APPROXIMATE MARKET VALUE	DATE DISPOSED

If further space is needed, please attach a separate sheet

**15. Criminal and Credit Information**

**Have you or another member of the household who intends to live in the unit:**

- a. Ever been convicted of a felony or any other criminal activity including a violation of the Controlled Substance Act within the past ten (10) years?  
 Yes  No
- b. Ever been convicted of a misdemeanor?  Yes  No
- c. Ever been convicted of a felony?  Yes  No
- d. Ever been evicted from Federally-assisted housing for drug-related criminal activity for three years from the date of eviction?  
 Yes  No
- e. Currently engaging in illegal drug use?  
 Yes  No
- f. Listed on a state sex offender registration program?  Yes  No
- g. Has your behavior from abuse or pattern of abuse of alcohol interfered with the health, safety and right to peaceful enjoyment by others?  Yes  No

**If the answer is “yes” to any of the above in this section please explain and include date(s) of occurrence:** \_\_\_\_\_

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

- h. Ever been late in payment of rental or housing payment within the past five years?  Yes  No

If “yes” please explain and include date(s) of occurrence(s).

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

**HUD regulations require that Asbury Harris Epworth Towers give preference to applicants who have been displaced by government action or a presidential declared disaster.**

- 16. Have applicant(s) been displaced by:**
- a. **Federal, State or local body or agency?** YES\_\_\_ NO\_\_\_
  - b. **Presidential declared disaster?** YES\_\_\_ NO\_\_\_

**17. Optional Information**

How did you hear about Asbury Harris Epworth Towers?

- Current resident or resident family member
- Friend
- Employee
- Religious organization

\_\_\_ Information provided by a government agency?  
\_\_\_ Advertisement (Where?) \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

Do you plan to use an assistive animal in this facility?  
\_\_\_ Yes \_\_\_ No

Do you have any special housing needs?  
\_\_\_ Yes \_\_\_ No If yes explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

**18. Applicant(s)' Certification**

I/we certify that if selected to move into this project, the unit I/we occupy will be my/our only residence. I/we understand that the above information is being collected to determine my/our eligibility for assistance. I/we authorize the owner/management to verify all information provided on this application and to contact previous or current landlords or other sources for credit, criminal background check, and verification information which may be released to appropriate Federal, State or Local agencies. I/we understand that our information will be kept confidential, but may be reviewed by a HUD representative. I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief. I/we understand that false statements or information are punishable under Federal Law, and could result in this application being rejected. I/we am/are aware that the applicant may be given less than thirty (30) days notice to move into an available apartment. If for any reason I/we am/are unable to move in within the allowed time, I/we understand that our offer may be forfeited. I/we also understand that it is a requirement of our placement on the Waiting List that I/we contact Asbury Harris Epworth Towers in writing every six (6) months should we decide to remain on the List. I/we understand that failure to complete this application in its entirety will result in the rejection of this application.

Signature of Head of Household: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse / Co-Head: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of **Asbury Harris Epworth Towers**

Representative: \_\_\_\_\_ Date: \_\_\_\_\_

ASBURY HARRIS EPWORTH TOWERS does not discriminate in any fashion based on a person's race, color, creed, sex, national origin, handicap status, religion, familial status or disability.

When would you like to move in? \_\_\_\_\_

**Date**