

**HOUSING AUTHORITY TOWN OF NEWTON
32 LIBERTY STREET
NEWTON, NEW JERSEY 07860
TELEPHONE: 973-383-5191 X 21 FAX: 973-383-1181**

INITIAL PRELIMINARY APPLICATION FOR SENIOR & DISABLED HOUSING

PLEASE PRINT CLEARLY

HEAD OF HOUSEHOLD (LEGAL NAMES) INDIVIDUAL MUST BE AT LEAST 55 YEARS & COLECTING SSD OR 62+

Last Name	First Name	M.I.
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HOME ADDRESS

Current Street Address:	Apt. #
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City:	State:	ZIP:
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MAILING ADDRESS

Mailing Address: Check here if same as above

City:	State:	ZIP:
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PERSONAL INFORMATION

Home Phone: ()	S.S.#	Date of Birth: / /	Place of Birth:
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Gender Male Female	Marital Status:	If Naturalized, provide the effective date:
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DEMOGRAPHIC INFORMATION

RACE	ETHNICITY	OWN PROPERTY YES NO
<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	SOLD PROPERTY IN LAST 3 YEARS YES NO
<input type="checkbox"/> African American	<input type="checkbox"/> Not Hispanic	
<input type="checkbox"/> American Indian/Alaska Native		
<input type="checkbox"/> Asian or Pacific Islander		

HEAD OF HOUSEHOLD CURRENT EMPLOYMENT INFORMATION (IF APPLICABLE)

Current Employer:

Employer Address:	How long?
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City:	State:	ZIP:	Supervisor's Name:
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Position:	Annual income: \$	Business Phone: ()
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HEAD OF HOUSEHOLD SOURCES OF INCOME & MEDICAL EXPENSES

<p>MONTHLY GROSS INCOME:</p> <p><input type="checkbox"/> Wages \$ _____</p> <p><input type="checkbox"/> Social Security \$ _____</p> <p><input type="checkbox"/> SSI \$ _____</p> <p><input type="checkbox"/> SSD \$ _____</p> <p><input type="checkbox"/> Pension \$ _____</p> <p><input type="checkbox"/> TANF \$ _____</p> <p><input type="checkbox"/> Other \$ _____</p> <p><input type="checkbox"/> Assets \$ _____</p> <p>Total <u>Monthly</u> Income \$ _____</p>	<p>MONTHLY MEDICAL EXPENSES:</p> <p><input type="checkbox"/> Medicare \$ _____</p> <p><input type="checkbox"/> Medicaid \$ _____</p> <p><input type="checkbox"/> Private Health Ins. \$ _____</p> <p><input type="checkbox"/> Out of Pocket Medical \$ _____</p> <p>(Copay not covered by insurance for ROUTINE VISITS: Hospitalization and Surgeries ARE NOT ROUTINE)</p> <p><input type="checkbox"/> Out of Pocket Prescriptions \$ _____ yearly</p> <p>(Copay not covered by insurance for routine prescription)</p>
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Do you require any modifications or accommodations in order to fully utilize the unit or the program and its services?
If yes, , please explain:

If English is not your primary language, will you require the Housing Authority to provide an interpreter?
If yes, indicate your primary language:

Do you own an automobile? Yes No If yes, how many? _____

Do you have any pets? Yes No If Yes, what type: _____

CONTINUE ON BACK PAGE

CO-HEAD INFORMATION (LEGAL NAMES)

Last Name		First Name		M.I.	Relationship to head of household:
Home Phone: ()		S.S.#	Date of Birth: / /		Place of Birth:
Gender Male Female	Marital Status:	If not Naturalized date you became a Citizen:			

CO-HEAD DEMOGRAPHIC INFORMATION

RACE		ETHNICITY	OWN PROPERTY YES NO
<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian or Pacific Islander		<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	SOLD PROPERTY IN LAST 3 YEARS YES NO

CO-HEAD'S CURRENT EMPLOYMENT INFORMATION

Current Employer:			How long?
Employer Address:			Annual Income: \$
City:	State:	ZIP:	Supervisor's Name:

CO-HEAD'S OTHER SOURCE OF INCOME

MONTHLY GROSS INCOME:		MONTHLY MEDICAL EXPENSES:	
<input type="checkbox"/> Wages	\$ _____	<input type="checkbox"/> Medicare	\$ _____
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Medicaid	\$ _____
<input type="checkbox"/> SSI	\$ _____	<input type="checkbox"/> Private Health Ins.	\$ _____
<input type="checkbox"/> SSD	\$ _____	<input type="checkbox"/> Out of Pocket Medical	\$ _____
<input type="checkbox"/> Pension	\$ _____	(Copay not covered by insurance for ROUTINE VISITS: Hospitalization and Surgeries ARE NOT ROUTINE)	
<input type="checkbox"/> TANF	\$ _____	<input type="checkbox"/> Out of Pocket Prescriptions	\$ _____ yearly
<input type="checkbox"/> Other	\$ _____	(Copay not covered by insurance for routine prescription)	
<input type="checkbox"/> Assets	\$ _____		
Total <u>Monthly</u> Income	\$ _____		

The following portion of the application applies to all household members

EMERGENCY CONTACT INFORMATION:

Name:	Relationship:	Address:	
Home Phone: ()	City:	State:	Zip:

LOCAL PREFERENCES:

<input type="checkbox"/> Newton Resident	<input type="checkbox"/> Disability (claim of disability for eligibility only)
<input type="checkbox"/> Sussex County Resident	<input type="checkbox"/> Rent burden (over 50% income is paid in rent)
<input type="checkbox"/> Displaced as a result of federally-declared disaster	

PROGRAM INTEGRITY:

Have you lived in assisted housing before? Yes No
 If yes, indicate when, where and under what name: _____

Have you been evicted from public or assisted housing and/or do you owe any money to a Public Housing Agency? Yes No

Have you ever used a name other than the one you are using now? Yes No
 If yes, what name? _____

Have you ever used a social security number other than the one you have listed? Yes No
 If yes, what is it? _____

Have you or any members of your household ever been arrested and/or convicted of any felony and/or misdemeanor other than a traffic violation? Yes No
 If yes, explain: _____

Has anyone in your household applied for any benefits or money, which is in the process of being approved? Yes No
 If yes, explain: _____

LANDLORD REFERENCES: (if applicable)**Please identify the address and the last three landlords below, starting with most recent:**

Landlord Name:

Landlord Address:

Landlord's telephone:

Your address (only if different from landlord's)

From

To

Reason for leaving:

Landlord Name:

Landlord Address:

Landlord's telephone:

Your address (only if different from landlord's)

From

To

Reason for leaving:

Landlord Name:

Landlord Address:

Landlord's telephone:

Your address (only if different from landlord's)

From

To

Reason for leaving:

AUTHORIZATIONS, REPRESENTATIONS & CERTIFICATIONS:

I do hereby authorize the Newton Housing Authority to obtain a consumer report as defined in the Fair Credit Reporting Act, 15 U.S.C. Sec 1681 a(d), seeking information on the credit worthiness, credit standing, credit capacity, general reputation, or mode of living of applicants.

I understand that any misrepresentation of information or failure to disclose information requested on this application may disqualify me from consideration for admission or participation and may be grounds for eviction or termination of assistance.

FAILURE TO FILL OUT ENTIRE APPLICATION IN FULL WILL PREVENT THE HOUSING AUTHORITY FROM PROCESSING YOUR APPLICATION. YOU ARE REQUIRED TO NOTIFY THE NEWTON HOUSING AUTHORITY OF ANY CHANGE OF ADDRESS. IF WE CANNOT CONTACT YOU AT THE GIVEN ADDRESS, YOUR NAME WILL BE REMOVED FROM THE WAITING LIST, AND YOU WILL HAVE TO RE-APPLY.

WARNING: SECTION 1001 OF TITLE 18 OF U.S. CODES MAKES IT A CRIMINAL OFFENSE TO MAKE WILLFUL FALSE STATEMENTS OF MISREPRESENTATION OF ANY DEPARTMENT OR AGENCY OF THE UNITED STATES AS TO ANY MATTERS WITHIN ITS JURISDICTION.

HEAD OF HOUSEHOLD

SIGNATURE _____

DATE _____

COHEAD OF HOUSEHOLD

SIGNATURE _____

DATE _____

OFFICE USE ONLY: Date sent out: _____ Date received: _____ Time: _____ Entered: _____