

# NEPTUNE CITY HOUSING AUTHORITY RENTAL APPLICATION

2000 6<sup>th</sup> Avenue  
Neptune City, NJ 07753  
732-988-2540  
Fax: 732-988-1587  
Section 8 – Project Base



## Application Must Be filled out Completely

**This section to be fill out by office:**

Time: \_\_\_\_\_  
Date Received: \_\_\_\_\_  
Received By: \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_

APT. SIZE REQUESTING: \_\_\_\_\_STUDIO \_\_\_\_\_ONE BEDROOM  
(One-bedroom apartments occupy 2 or more persons *ONLY*)

CURRENT ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

***IMPORTANT:*** ANY CHANGES TO THE ABOVE INFORMATION MUST BE REPORTED TO OFFICE TO REMAIN ON OUR ACTIVE WAITLIST.

## HOUSEHOLD COMPOSITION

*(Must Complete All)*

1. HEAD OF HOUSEHOLD (HOH) FIRST AND THE OTHER MEMBERS WHO WILL BE LIVING IN THE UNIT.
2. CO-TENANT AND THEIR RELATIONSHIP TO HOH.

	<u>FULL NAME</u>	<u>RELATION</u>	<u>BIRTHDATE</u> <u>AGE/SEX</u>	<u>SSN</u>
(1)	_____	<u>Head</u>	_____ (M / F/Other)	_____
(2)	_____	<u>Co-Tenant</u>	_____ (M / F/Other)	_____

INCOME

TYPE OF INCOME

MONTHLY

*(SSI, PENSION, ETC.)*

AMOUNT

(1) \_\_\_\_\_

\_\_\_\_\_

\$ \_\_\_\_\_

(2) \_\_\_\_\_

\_\_\_\_\_

\$ \_\_\_\_\_

Disabled?  Yes  No

Accessibility Needed?  Yes  No

Please identify any special housing needs (if any) your household has: \_\_\_\_\_

\_\_\_\_\_

Veteran?  Yes  No

DOES ANYONE CURRENTLY LIVE WITH YOU WHO IS NOT LISTED ABOVE:

YES  NO

6. DO YOU EXPECT A CHANGE IN YOUR HOUSEHOLD COMPOSITION:

YES  NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. ARE YOU CURRENTLY LIVING IN A SUBSIDIZED HOUSING UNIT?

YES  NO

*IF YES, PLEASE PROVIDE:*

NAME/ADDRESS OF COMPLEX: \_\_\_\_\_

NAME OF MANAGER: \_\_\_\_\_

MANAGER'S TELEPHONE NUMBER: \_\_\_\_\_

8. ARE ANY MEMBERS OF THE PROPOSED HOUSEHOLD SUBJECT TO STATE LIFETIME SEX OFFENDER REGISTRATION IN ANY STATE?

YES  NO

10. PLEASE LIST ALL STATES YOU OR ANY MEMBERS OF THE PROPOSED HOUSEHOLD HAVE RESIDED IN.

\_\_\_\_\_

**EMPLOYMENT HISTORY** *(IF APPLICABLE)*

NAME AND ADDRESS OF PRESENT EMPLOYER *(PLEASE WRITE N/A IF NOT APPLICABLE)*

**HEAD:**

TELEPHONE: \_\_\_\_\_  
SUPERVISOR'S NAME: \_\_\_\_\_  
HOW LONG? \_\_\_\_\_

**CO-APPLICANT**

TELEPHONE: \_\_\_\_\_  
SUPERVISOR'S NAME: \_\_\_\_\_  
HOW LONG? \_\_\_\_\_

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**RENTAL HISTORY**

*(Must Complete)*

***Important:*** If you lived with a family member, please enter their information.

Name and address of Present Landlord:

Telephone Number: \_\_\_\_\_  
How long have you lived there? \_\_\_\_\_  
Reason for wanting to Leave? \_\_\_\_\_

Name and address of your Former Landlord:

Telephone Number: \_\_\_\_\_  
How long have you lived there? \_\_\_\_\_  
Reason for Leaving? \_\_\_\_\_

Name and address of your Former Landlord:

Telephone Number: \_\_\_\_\_  
How long have you lived there? \_\_\_\_\_  
Reason for Leaving? \_\_\_\_\_

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**INCOME AND ASSET INFORMATION**

**(PLEASE CIRCLE ANSWER)**

*PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS. (FOR EACH "YES" PROVIDE MORE DETAILS)*

**DOES APPLICANT and/or CO-APPLICANT (PLEASE CIRCLE ANSWER)**

- |     |    |     |  |
|-----|----|-----|--|
| YES | NO | 1.  | WORK FULL TIME, PART-TIME OR SEASONALLY?   |
| YES | NO | 2.  | EXPECT TO WORK FOR ANY PERIOD DURING THE NEXT YEAR.  |
| YES | NO | 3.  | WORK FOR SOMEONE WHO PAYS CASH?  |
| YES | NO | 4.  | EXPECT A LEAVE OF ABSENCE FROM WORK DUE TO LAY-OFF?  |
| YES | NO | 5.  | ON MEDICAL, MATERNITY OR MILITARY LEAVE?   |
| YES | NO | 6.  | NOW RECEIVE OR EXPECT TO RECEIVE UI BENEFITS?  |
| YES | NO | 7.  | NOW RECEIVE OR EXPECT TO RECEIVE ALIMONY?  |
| YES | NO | 8.  | HAS AN ENTITLEMENT TO RECEIVE ALIMONY THAT IS NOT CURRENTLY BEING RECEIVED?  |
| YES | NO | 9.  | RECEIVE OR EXPECT TO RECEIVE PUBLIC ASSISTANCE?  |
|     |    | 10. | RECEIVE OR EXPECT TO RECEIVE SOCIAL SECURITY OR DISABILITY BENEFITS?   |
| YES | NO | 11. | RECEIVE OR EXPECT TO RECEIVE INCOME FROM A PENSION OR ANNUITY?   |
| YES | NO | 12. | RECEIVE OR EXPECT TO RECEIVE REGULAR CONTRIBUTIONS FROM ORGANIZATIONS OR FROM INDIVIDUALS NOT LIVING IN THE UNIT?  |
| YES | NO | 13. | RECEIVE INCOME FROM ASSETS INCLUDING INTEREST ON CHECKING OR SAVINGS ACCOUNTS, DIVIDENDS, CERTIFICATES OF DEPOSIT, STOCKS, BONDS OR INCOME FROM RENTAL PROPERTY? |
| YES | NO | 14. | OWN REAL ESTATE OR ANY ASSETS FOR WHICH YOU RECEIVE INCOME (CHECKING ACCOUNT, CASH)?   |
| YES | NO | 15. | HAVE YOU SOLD OR GIVEN AWAY REAL PROPERTY OR OTHER ASSETS (INCLUDING CASH) IN THE PAST TWO YEARS?  |

*ADD 'L INFO:* \_\_\_\_\_  
\_\_\_\_\_

**STATISTICAL INFORMATION (MUST COMPLETED)**

**3. RACE OF HEAD OF HOUSEHOLD**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> WHITE                  | <input type="checkbox"/> BLACK       | <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE |
| <input type="checkbox"/> ASIAN/PACIFIC ISLANDER | <input type="checkbox"/> TWO OR MORE |   |

4. ETHNICITY OF HEAD OF HOUSEHOLD (FOR STATISTICAL PURPOSES ONLY)

HISPANIC       NON-HISPANIC

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**ASSETS**

LIST ALL CHECKING AND SAVINGS ACCOUNTS (INCLUDING IRAS, KEOGH ACCOUNTS COD'S) FOR APPLICANT & CO-APPLICANT: *(Must Complete)*

	<u>BANK NAME</u>	<u>TYPE OF ACCOUNT</u>	<u>BALANCE</u>
1.	_____	_____	\$ _____
2.	_____	_____	\$ _____
3.	_____	_____	\$ _____
4.			

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**MEDICAL EXPENSES/INFORMATION**

YES       NO DO YOU PAY ANY NECESSARY EXPENSE FOR MEDICATIONS, EQUIPMENT, CARE ATTENDANT OR ANY OTHER SERVICES?  
*(Must Provide Proof if selected)*

*IF YOU PAY A CARE ATTENDANT, PROVIDE THEIR:*

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

**PLEASE ANSWER MEDICAL INFORMATION**

YES       NO DO YOU HAVE MEDICARE? IF YES, WHAT IS YOUR MONTHLY PREMIUM? \$ \_\_\_\_\_

YES       NO DO YOU HAVE ANY OTHER KIND OF MEDICAL INSURANCE?  
*IF YES, ANSWER THE FOLLOWING QUESTIONS PLEASE PROVIDE:*

NAME: \_\_\_\_\_

PREMIUM AMOUNT: \_\_\_\_\_

YES       NO OUTSTANDING MEDICAL BILLS? IF YES, AMOUNT: \_\_\_\_\_

IF YOU USE THE SAME PHARMACY REGULARLY, PLEASE PROVIDE THE NAME AND ADDRESS:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

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**APPLICANT CERTIFICATION:**

I/WE CERTIFY THAT IF SELECTED TO RECEIVE ASSISTANCE, 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. I/WE AUTHORIZE THE OWNER/MANAGER/PHA TO VERIFY ALL INFORMATION PROVIDED ON THIS APPLICATION AND TO CONTACT PREVIOUS OR CURRENT LANDLORDS OR OTHER SOURCES OF CREDIT AND VERIFICATION INFORMATION WHICH MAY BE RELEASED TO APPROPRIATE FEDERAL, STATE, OR LOCAL AGENCIES. I/WE AUTHORIZE THE OWNER/MANAGER TO DO A CRIMINAL BACKGROUND CHECK TO DETERMINE MY/OUR ELIGIBILITY. I/WE UNDERSTAND THAT FALSE STATEMENTS OR INFORMATION ARE PUNISHABLE UNDER FEDERAL LAW.

**SIGNATURE OF HEAD:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**SIGNATURE OF SPOUSE/CO-HEAD:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEWED BY OWNER/MANAGER/PHA REPRESENTATIVE:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_