

# APPLICATION FOR HOUSING

HUD Property

**Office Use Only**

Mgr. Signature:

Date:

Time:

This is an application for housing at:  
Please complete this application and  
return to Area Agency on Aging of

**Complex Name:**

**City:**

Northwest Arkansas

Phone: 870-741-1144, FAX: 870-741-6214 Toll  
free: 800-432-9721, TDD 800/741-1346

Managed by Area Agency on Aging of  
Northwest Arkansas

Applications are placed on waiting list in order of date and time received. An applicant may be interviewed only after the receipt of this tenant application. **If any section does not apply to you, fill in with "n/a" or "does not apply."**

## A. GENERAL INFORMATION

**Please Print Clearly**

Applicant Name(s): \_\_\_\_\_

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

Street

Apt.#

City

State

ZIP

Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Are you seeking housing due to a Presidentially Declared Disaster?

Yes

No

Citizenship Status (check one)

United States Citizen

Eligible Non-Citizen

Ineligible Non-Citizen

Do you  RENT or  OWN or  HOMELESS (check one)

How did you hear about the property? \_\_\_\_\_

Amount of current monthly rental or mortgage payment: \$ \_\_\_\_\_

If owned, do you receive monthly rental income from property?

YES

NO

(check one)

**\*\*Attach copy of your Social Security Card and proof of age, i.e. driver's license, state ID, birth certificate, etc. for all household members. If you have no Social Security Number, you claim you are exempt because: You are an ineligible non-citizen or you were 62 as of 1/31/10 and receiving HUD housing assistance as of 1/31/10.**

	Name	Veteran	Need an accessible unit?	Student Status	Birth Date	Age	SS#
Head	<input type="text"/>	<input type="text" value="No"/>	<input type="text" value="No"/>	<input type="text" value="No"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Co-H	<input type="text"/>	<input type="text" value="No"/>	<input type="text"/>	<input type="text" value="No"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text" value="No"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



We do not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, our federally assisted programs and activities. If you are disabled and would like to request an accommodation or if you have difficulty understanding English, please request our assistance and we will ensure that you are provided with meaningful access based on your individual needs. Federal civil rights laws addressing fair housing prohibit discrimination against applicants or tenants based on one or more of the following classifications: race, color, national origin, sexual orientation, gender identification, disability, religion, and familial status.

**C. INCOME**

List ALL sources of income as requested below. If a section doesn't apply, cross out or write NA. **Must supply complete addresses and phone numbers on last page of application.**

Household Member Name	Source of Income	Gross Monthly Amount
_____	Social Security	\$ _____
_____	Social Security	\$ _____
_____	SSI Benefits	\$ _____
_____	SSI Benefits	\$ _____
_____	Pension (list source)	\$ _____
_____	Pension (list source)	\$ _____
_____	Veteran's Benefits (list claim #)	\$ _____
_____	Veteran's Benefits (list claim #)	\$ _____
_____	Interest Income (source)	\$ _____
_____	Interest Income (source)	\$ _____
	<b>Employment amount</b>	\$ _____
	Employer: _____	
	Position Held: _____	
	How long employed: _____	
	Custody Arrangement of any Children? If	<input type="checkbox"/> YES <input type="checkbox"/> NO
	yes, explain: _____	
	<b>Alimony</b>	
	Are you <i>entitled</i> to receive alimony?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If yes, list the amount you are <i>entitled</i> to receive.	\$ _____
	Do you receive alimony?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If yes list amount you receive.	\$ _____
	<b>Other Income</b>	\$ _____
	<b>Other Income</b>	\$ _____

**TOTAL GROSS ANNUAL INCOME** (Based on the monthly amounts listed above x 12) \$ \_\_\_\_\_

**TOTAL GROSS ANNUAL INCOME FROM PREVIOUS YEAR** \$ \_\_\_\_\_

Do you anticipate any changes in this income in the next 12 months?  YES     NO

If yes, explain: \_\_\_\_\_

**D. ASSETS**

If your assets are too numerous to list here, please request an additional form. If a section doesn't apply, cross out or write NA. **Must supply complete addresses and phone numbers on last page of application.**

	Bank	Balance
<b>Checking Accounts #</b> _____	_____	\$ _____
# _____	_____	\$ _____
<b>Savings Accounts #</b> _____	_____	\$ _____
# _____	_____	\$ _____
<b>Trust Account #</b> _____	_____	\$ _____
# _____	_____	\$ _____
<b>Direct Express Debit #</b> _____	_____	\$ _____
<b>Card #</b> _____	_____	\$ _____
<b>Reloadable Prepaid Card #</b> _____	_____	\$ _____
# _____	_____	\$ _____

**Certificates of Deposit** # \_\_\_\_\_ Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_  
 # \_\_\_\_\_ Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_

**Credit Union Savings Bonds** # \_\_\_\_\_ Bank \_\_\_\_\_ Balance \$ \_\_\_\_\_  
 # \_\_\_\_\_ Maturity Date \_\_\_\_\_ Value \$ \_\_\_\_\_

**Life Insurance Policy** # \_\_\_\_\_ Cash Value \$ \_\_\_\_\_  
**Life Insurance Policy** # \_\_\_\_\_ Cash Value \$ \_\_\_\_\_

**Mutual Fund** Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Interest or Dividend \$ \_\_\_\_\_ Value \$ \_\_\_\_\_  
 Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Interest or Dividend \$ \_\_\_\_\_ Value \$ \_\_\_\_\_

**Stocks** Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Dividend Paid \$ \_\_\_\_\_ Value \$ \_\_\_\_\_  
 Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Dividend Paid \$ \_\_\_\_\_ Value \$ \_\_\_\_\_

**Bonds** Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Interest or Dividend \_\_\_\_\_ Value \$ \_\_\_\_\_  
 Name: \_\_\_\_\_ #Shares: \_\_\_\_\_ Interest or Dividend \_\_\_\_\_ Value \$ \_\_\_\_\_  
 Appraised Value \$ \_\_\_\_\_

**Investment Property**

Real Estate Property: *Do you own any property?*  YES  NO

*If yes, Type of property* \_\_\_\_\_

Location of property \_\_\_\_\_

Appraised Market Value \$ \_\_\_\_\_

Mortgage or outstanding loans balance due \$ \_\_\_\_\_

Amount of annual insurance premium \$ \_\_\_\_\_

Amount of most recent tax bill \$ \_\_\_\_\_

Have you sold/dispensed of any property in the last 2 years?  YES  NO

*If yes, Type of property* \_\_\_\_\_

Market value when sold/dispensed \$ \_\_\_\_\_

Amount sold/dispensed 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 the asset* \_\_\_\_\_ Date of disposition \_\_\_\_\_  
 \_\_\_\_\_ Amount \_\_\_\_\_ disposed  
 \$ \_\_\_\_\_

Do you have any other assets not listed above (excluding personal property)?  YES  NO

*If yes, please list:*

**E. Medical Providers / Expenses**

Do you pay a monthly Medicare premium:

YES  NO

*If yes, please list:*

Amount of premium: \$ \_\_\_\_\_

Do you pay for a supplemental insurance policy such as AARP, Blue Cross, etc.

YES  NO

*If yes, please list:*

Amount of monthly premium paid by you: \$ \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of company: \_\_\_\_\_

List name of all pharmacies:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

List name of all hospitals:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

List name of all doctors: (medical, dental, eye, etc.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

Examples of other medical expenses are: Services of health care facilities such as laboratory fees, x-rays and diagnostic tests, blood, and oxygen, dental treatment, attendant care, payments on accumulated medical bills, nonprescription over-the-counter medicines (aspirin, cough drops, vitamins, incontinence supplies, diabetes supplies, etc.), transportation to/from treatment (actual cost or if driving by car, a mileage rate based on IRS rules or other accepted standard), or any other medically-necessary services, apparatus or medication, as documented by third party verifications. Non-recurring, one-time expenses are excluded.

**Use the last page of application to list medical providers, their names, addresses, and phone numbers.**

**F. ADDITIONAL INFORMATION**

Are you or any member of your family currently using an illegal substance?

YES  NO

Have you or any member of your family ever been convicted of a felony?

YES  NO

*If yes, describe when and where* \_\_\_\_\_

Have you or any member of your family ever been evicted from any housing for lease violation including drug use or failure to report a crime?

YES  NO

*If yes, describe* \_\_\_\_\_

Are you or is any member of the household required to register with any state lifetime sex offender or other sex offender registry?

YES  NO

**List all states which you and members of the household have resided.** \_\_\_\_\_

Have you ever filed for bankruptcy?

YES  NO

*If yes, describe* \_\_\_\_\_

Will you take an apartment when one is available?

YES  NO

**Briefly describe your reasons for applying:** \_\_\_\_\_

## G. REFERENCE INFORMATION

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

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

### Current Landlord

Home Phone: \_\_\_\_\_

Bus. Phone: \_\_\_\_\_

How Long? \_\_\_\_\_

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

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

### Prior Landlord

Home Phone: \_\_\_\_\_

Bus. Phone: \_\_\_\_\_

How Long? \_\_\_\_\_

### Personal Reference #1 (not a family member):

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

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Personal Reference #2:

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

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## H. PET INFORMATION (if applicable)

Do you own any pets?  YES  NO If yes, describe: \_\_\_\_\_

## CERTIFICATION

I/We hereby certify that I/We Do/Will Not maintain a separate subsidized rental unit in another location. I/We further certify that this will be my/our permanent residence. I/We understand I/We must pay a security deposit for this apartment prior to occupancy. I/We understand that my eligibility for housing will be based on applicable income limits and by management's selection criteria. I/We certify that all information in this application is true to the best of my/our knowledge and I/We understand that false statements or information are punishable by law and will lead to cancellation of this application or termination of tenancy after occupancy.

SIGNATURE (S):

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Applicant

\_\_\_\_\_  
Date



*We do not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, our federally assisted programs and activities. If you are disabled and would like to request an accommodation or if you have difficulty understanding English, please request our assistance and we will ensure that you are provided with meaningful access based on your individual needs. Federal civil rights laws addressing fair housing prohibit discrimination against applicants or tenants based on one or more of the following classifications: race, color, national origin, sexual orientation, gender identification, disability, religion and familial status.*



**MUST PROVIDE COMPLETE ADDRESSES AND PHONE NUMBERS OF ALL SOURCES OF INCOME, ASSETS, AND MEDICAL PROVIDERS WITH WHOM YOU HAVE PAID OUT OF POCKET EXPENSES DURING THE PAST 12 MONTHS.**

_____
_____
_____
Phone _____
_____
_____
_____
Phone _____
_____
_____
_____
Phone _____
_____
_____
_____

_____
_____
_____
Phone _____
_____
_____
_____
Phone _____
_____
_____
_____
Phone _____
_____
_____
_____

Updated 07/27/2017 Application Housing HUD

*The position named below has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development's regulations implementing*

*Section 504 {24 CFR, part 8 dated June 2, 1988}.*

Company/Property	Area Agency on Aging
Position:	504 Coordinator
Address	1510 Rock Springs Road
Address	PO Box 1795
City, State, Zip	Harrison, Arkansas, 72601
Phone	1-800-432-9721
Fax	(870) 741-1984
Email	info@aanwar.org
TTY (Audio Relay)	(870) 741-1346

# Property

---

## HOUSING WAITING LIST POLICY

I UNDERSTAND THAT I AM ON THE ACTIVE WAITING LIST FOR A ONE-BEDROOM APARTMENT IN THE ABOVE-NAMED APARTMENT COMPLEX. IN ORDER TO STAY ON THE ACTIVE WAITING LIST, I MUST VISIT OR CONTACT THE RENTAL OFFICE WITHIN SIX MONTHS OF THE DATE BELOW. AT THAT TIME, I WILL REPORT ANY CHANGES IN FAMILY SIZE, INCOME, ETC. IF AT ANY TIME MY ADDRESS OR TELEPHONE NUMBER SHOULD CHANGE, I WILL NOTIFY THE MANAGER IMMEDIATELY.

IF I AM DISABLED AND UNABLE TO COMPLETE THE APPLICATION PROCESS, I CAN REQUEST AN ALTERNATIVE METHOD BE PROVIDED.

I ALSO UNDERSTAND THAT IF I DO NOT CONTACT THE RENTAL OFFICE BY THE SPECIFIED DATE, I WILL NO LONGER BE ON THE ACTIVE WAITING LIST. APPLICANTS WILL BE OFFERED AN AVAILABLE APARTMENT A MAXIMUM OF 3 TIMES PER APARTMENT ALL 3 TIMES THEIR NAME WILL BE REMOVED FROM THE WAITING LIST. WE WILL INFORM THE PROSPECTIVE TENANT THAT THEY NEED TO RE-APPLY AND THEIR NAME WILL GO TO THE BOTTOM OF THE WAITING LIST ONCE THE NEW APPLICATION IS RECEIVED.

Print Name \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**Return this Copy with Your Application**

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants  
 SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING  
 This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

<b>Applicant Name:</b>	
<b>Mailing Address:</b>	
Telephone No:	Cell Phone No:
<b>Name of Additional Contact Person or Organization:</b>	
Address:	
Telephone No:	Cell Phone No:
E-Mail Address (if applicable):	
<b>Relationship to Applicant:</b>	
Reason for Contact: (Check all that apply)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Assist with Recertification Process
<input type="checkbox"/> unable to contact you	<input type="checkbox"/> Change in lease terms
<input type="checkbox"/> Termination of rental assistance	<input type="checkbox"/> Change in house rules
<input type="checkbox"/> Eviction from unit	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Late payment of rent	
<b>Commitment of Housing Authority or Owner:</b> If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.	
<b>Confidentiality Statement:</b> The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
<b>Legal Notification:</b> Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.	

Check this box if you choose not to provide the contact information.

_____	_____
Signature of Applicant	Date

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.



# Property

---

## HOUSING WAITING LIST POLICY

I UNDERSTAND THAT I AM ON THE ACTIVE WAITING LIST FOR A ONE-BEDROOM APARTMENT IN THE ABOVE-NAMED APARTMENT COMPLEX. IN ORDER TO STAY ON THE ACTIVE WAITING LIST, I MUST VISIT OR CONTACT THE RENTAL OFFICE WITHIN SIX MONTHS OF THE DATE BELOW. AT THAT TIME, I WILL REPORT ANY CHANGES IN FAMILY SIZE, INCOME, ETC. IF AT ANY TIME MY ADDRESS OR TELEPHONE NUMBER SHOULD CHANGE, I WILL NOTIFY THE MANAGER IMMEDIATELY.

IF I AM DISABLED AND UNABLE TO COMPLETE THE APPLICATION PROCESS, I CAN REQUEST AN ALTERNATIVE METHOD BE PROVIDED.

I ALSO UNDERSTAND THAT IF I DO NOT CONTACT THE RENTAL OFFICE BY THE SPECIFIED DATE, I WILL NO LONGER BE ON THE ACTIVE WAITING LIST. APPLICANTS WILL BE OFFERED AN AVAILABLE APARTMENT A MAXIMUM OF 3 TIMES PER APARTMENT ALL 3 TIMES THEIR NAME WILL BE REMOVED FROM THE WAITING LIST. WE WILL INFORM THE PROSPECTIVE TENANT THAT THEY NEED TO RE-APPLY AND THEIR NAME WILL GO TO THE BOTTOM OF THE WAITING LIST ONCE THE NEW APPLICATION IS RECEIVED.

Print Name \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**Keep this Copy for Your Records**



*We do not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, our federally assisted programs and activities. If you are disabled and would like to request an accommodation or if you have difficulty understanding English, please request our assistance and we will ensure that you are provided with meaningful access based on your individual needs. Federal civil rights laws addressing fair housing prohibit discrimination against applicants or tenants based on one or more of the following classifications: race, color, national origin, sexual orientation, gender identification, disability, religion and familial status.*



Submit completed application by printing and sending it to:

Housing Department  
Area Agency on Aging of NW AR  
P.O. Box 1795  
Harrison, AR 72602-1795  
Fax #: 870-741-6214  
Email: info@aanwar.org

Or send it directly to the Complex you are applying to, by selecting the Complexes link on the website for the Individual Complex information.

Thank you for your interest in our Housing Complexes at Area Agency on Aging of NW AR.

*Please report any difficulties you may experience with this application to our Housing Department at 1-800-432-9721.*