Supportive Living, INC.
BRAIN INJURY PROGRAMS

APPLICATION FOR HOUSING AND SERVICES

at

Warren House	Mclaughlin House	Douglas House	Old Farm Rockport
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

Introduction

Supportive Living, Inc. (SLI) affordable housing properties are designed to meet the needs of people with disabilities who would benefit from the supportive services available.

Warren House is equipped to house 16 individuals and consists of 11 apartments, 5 with 2 bedrooms and 6 1-bedroom units. There is a kitchen and living room in each apartment. Each person living at Warren House has his/her own bedroom and bathroom. Common areas include a large common living room, laundry room, and an outside patio.

McLaughlin House is home to 8 individuals who each have a bedroom and bathroom. There is a large common living room, parlor, dining room, kitchen, laundry room and an outside patio.

Douglas House will accommodate 15 individuals each with their own private bedroom, bathroom, and an option for a mini kitchen. Common areas include a parlor, dining room, kitchen, laundry room, TV room, sitting area, and an outside patio and deck.

Old Farm Rockport consists of two buildings and can accommodate 6 individuals. The main building, Norwood House, has four 1st floor bedrooms. The second building, Murphy House, has two studio style bedroom units on the 1st floor.

Supportive Living, Inc., has entered into an agreement with Advocates, Inc. of Framingham, MA to provide supportive services.

Accordingly, each individual with a disability who desires to become a resident must complete two application forms and one authorization forms to release medical record information, as follows:

1. Application for Housing
2. Application for Services
3. Authorization to release Medical Record information

The instructions, on the next page, are for both applications and authorization forms.

Instructions

1. Please type or print all sections in black ink. Do not leave any sections blank, even those which do not apply to you. For instance, if a section asks for a driver's license and you do not have a driver's license, enter "none" or "N/A" (not applicable). If you need to make a correction, draw one line through the incorrect information. Then print the correct information above to note the change.

2. It is important that all information on both of these forms be complete and correct. False, incomplete or misleading information will cause your application to be rejected.

3. Please send your application to:

   Supportive Living, Inc.
   400 West Cummings Park #6100
   Woburn, MA 01801

4. As long as your application is on file with us, it is your responsibility to contact and inform us regarding any changes in your address, telephone number, income situation or other changes in your housing status that might affect your application.

5. After we review your application, we will make a preliminary determination of eligibility. If you appear to be eligible for housing and services, your application will be placed on a Waiting List. Having your name on the Waiting List does not guarantee that you will be offered housing. If later evaluation establishes that you are not qualified for Housing and Services, your application will be rejected and you will be so notified. We will process your application according to our standard procedures, which are summarized in the Tenant Selection Plan posted in the Management Office.

WARNING

Section 1001 of Title 18 of US Code makes it a criminal offense to make willful, false statements or misrepresentations of any material facts involving the use of or obtaining Federal funds.

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

Director of Operations: Pam Morrissey
Phone: 781-937-3199
Email: pmorrissey@supportivelivinginc.org

Application for Housing

PLEASE TYPE OR PRINT IN INK

FULL LEGAL NAME: _____

HOME ADDRESS: _____

_____ ZIP: _____

EMAIL ADDRESS: _____

HOME # _____ CELL # _____ WORK #: _____

1. SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

2. THE ABOVE RESIDENCE IS:

OWN HOME: _____ NURSING HOME: _____
PARENTS HOME: _____ REHAB CENTER: _____
APARTMENT: _____ OTHER (SPECIFY): _____

How did you hear about this housing opportunity (if a publication, please specify which one)?

_____

_____

_____

3. IF I CAN NOT BE REACHED AT THE ABOVE NUMBER, PLEASE CONTACT:

PERSON TO CONTACT: _____ TEL #: ( ) _____

RELATIONSHIP: _____

4. HAVE YOU EVER USED A DIFFERENT NAME FROM THE NAME SHOWN ABOVE?
NO _____ YES _____ PLEASE LIST NAMES USED AND THE DATES WHEN SUCH NAME WERE IN USE:

_____

_____

Is there someone currently living in your home that will not be moving in with you?

_____

Do you anticipate any additions to the household in the next 12 months? NO _____ YES _____
*If yes, please explain*_____

_____

EQUAL OPPORTUNITY HOUSING

5. HAVE YOU EVER BEEN EVICTED OR OTHERWISE REMOVED FROM RENTAL HOUSING:

NO _____ YES _____ PLEASE PROVIDE LANDLORD NAME, ADDRESS AND DATES AND REASON FOR EVICTION OR REMOVAL.

_____

_____

_____

6. HAS ANY PLACE WHERE YOU WERE LIVING BEEN DESTROYED/DAMAGED BY FIRE?

NO _____ YES _____ PLEASE PROVIDE DETAILS AND DATES:

_____

_____

_____

_____

7. LIST ALL FULL-TIME, PART-TIME AND SEASONAL EMPLOYMENT (SUPPORTIVE OR COMPETITIVE) INCLUDING SELF EMPLOYMENT WITHIN THE PAST 5 YEARS:

PLACE OF EMPLOYMENT: _____

ADDRESS: _____

CITY/TOWN/STATE: _____

TELEPHONE #: _____

DATES: FROM: _____ TO: _____

PLACE OF EMPLOYMENT: _____

ADDRESS: _____

CITY/TOWN/STATE: _____

TELEPHONE #: _____

DATES: FROM: _____ TO: _____

PLACE OF EMPLOYMENT: _____

ADDRESS: _____

CITY/TOWN/STATE: _____

TELEPHONE #: _____

DATES: FROM: _____ TO: _____

8. LIST NON-EMPLOYMENT INCOME AS FOLLOWS:

TYPE INCOME	ESTIMATED TOTAL $ FOR NEXT 12 MONTHS	TYPE INCOME	ESTIMATED TOTAL $ FOR NEXT 12 MONTHS
INTEREST:	_____	UNEMPLOYMENT COMPENSATION:	_____
DIVIDENDS:	_____	ALIMONY:	_____
FROM RENTAL PROPERTY:	_____	CHILD SUPPORT:	_____
SOCIAL SECURITY:	_____	WORKERS COMPENSATION:	_____
PENSIONS:	_____	DISABILITY COMPENSATION:	_____
PUBLIC ASSISTANCE:	_____	ALL OTHER INCOME:	_____
SSI:	_____		
SSDI:	_____		

9. LIST ASSETS AS FOLLOWS:

TYPE OF ASSET	ESTIMATED CURRENT VALUE	ESTIMATED ANNUAL INCOME FROM ASSETS
CHECKING ACCOUNT (S):	_____	_____
SAVINGS ACCOUNT (S)	_____	_____
TRUST ACCOUNT (S)	_____	_____
CERTIFICATES (CD'S)	_____	_____
STOCKS(S)	_____	_____
LIFE INSURANCE POLICY	_____	_____
BOND (S):	_____	_____
CREDIT UNION SHARES:	_____	_____
LAND:	_____	_____
REAL ESTATE:	_____	_____
OTHER ASSETS:	_____	_____

Are you applying for a Market Rate Unit? NO _____ YES _____

Will the person/s in the household be or have been full-time students during five calendar months of this year or plan to be in the next calendar year at an educational institution. NO _____YES _____

IF YES, please answer the following questions:

	Yes	No
Are any full-time student(s) married and filing a joint tax return?		
Are any student(s) enrolled in a job-training program receiving assistance under the Job Training Partnership Act (JTPA)?		
Are any full-time student(s) a TANF or Title IV recipient?		
Are any full-time student(s) a single parent living with his/her minor child who is not a Dependent on another person/tax return?		

OPTIONAL: Do you or any member of your household classify yourself as any of the following? (This may include more than one group). Responses will help us track the diversity of the applicant pool. Your entry will have no bearing on your eligibility for housing.

□ White/Caucasian □ Latino/a □ Asian/Native Hawaiian/Pacific Islander/Alaskan
□ Native American
□ Black/African-/Caribbean-American □ Another race (please specify): _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES OR NO AND USE THE SPACE PROVIDED TO EXPLAIN ANY YES QUESTION.

A. DO YOU RECEIVE REGULAR CASH CONTRIBUTIONS FROM AGENCIES OR FROM INDIVIDUALS NOT LIVING WITH YOU?

NO ____ YES ____ _____

B. DO YOU RECEIVE INCOME FORM ASSETS, INCLUDING INTEREST, DIVIDENDS, STOCKS, OR BONDS?

NO ____ YES ____ _____

C. DO YOU RECEIVE MONEY FROM SCHOOL-AID, SCHOLARSHIP OR EDUCATIONAL GRANT?

NO ____ YES ____ _____

D. HAVE YOU SOLD OR GIVEN AWAY ANY MONEY, REAL ESTATE PROPERTY OR OTHER ASSETS IN THE PAST TWO YEARS?

NO ____ YES ____ _____

E. DO YOU CURRENTLY USE ANY ILLEGAL DRUG OR OTHER ILLEGAL CONTROLLED SUBSTANCE?

NO ____ YES ____ _____

F. HAVE YOU EVER ENGAGED IN OR BEEN CONVICTED OF DRUG-RELATED CRIMINAL ACTIVITY, SUCH AS USE, POSSESSION, DISTRIBUTION, TRAFFICKING, OR MANUFACTURE OF AN ILLEGAL DRUG?

NO ____ YES ____ _____

G. HAVE YOU BEEN INVOLVED IN OR BEEN CONVICTED OF CRIMINAL ACTIVITY THAT POSE A THREAT TO THE HEALTH, SAFETY OR WELFARE OF OTHERS?

NO ____ YES ____ _____

_____INITIALS

CERTIFICATION:

I CERTIFY THAT ALL INFORMATION GIVEN IN THIS APPLICATION AND ANY ADDENDUM THERETO IS TRUE, COMPLETE AND ACCURATE.

I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS FALSE, MISLEADING OR INCOMPLETE, MANAGEMENT MAY DECLINE MY APPLICATION OR, IF MOVE-IN HAS OCCURRED, TERMINATE MY RENTAL AGREEMENT.

I AUTHORIZE THE PROPERTY MANAGER TO MAKE ANY AND ALL INQUIRIES TO VERIFY THIS INFORMATION EITHER DIRECTLY OR THROUGH INFORMATION EXCHANGED NOW OR LATER WITH RENTAL AND CREDIT SCREENING SERVICES, AND TO CONTACT PREVIOUS AND CURRENT LANDLORDS OR OTHER SOURCES FOR CREDIT AND VERIFICATION CONFIRMATION WHICH MAY BE RELEASED TO APPROPRIATE FEDERAL, STATE OR LOCAL AGENCIES.

I AGREE TO NOTIFY MANAGEMENT IN WRITING REGARDING ANY CHANGES IN HOUSEHOLD ADDRESS, TELEPHONE NUMBERS, INCOME, AND HOUSEHOLD COMPOSITION.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS APPLICATION, IN PARTICULAR, THE INFORMATION CONTAINED IN THE INSTRUCTIONS AND AGREE TO COMPLY WITH SUCH INFORMATION.

_____ _____

DATE SIGNATURE OF APPLICANT

APPLICATION CHECKLIST

Your application is not considered complete without the following documents. Documents will not be returned; please submit copies only. Supportive Living reserves the right to request additional documentation as necessary.

Some of the Income documentation required for each household member include:

- Copies of Birth Certificate and social security card.
- If applicable, SIX weeks' worth of most recent pay stubs.
- If applicable, documentation of all other sources of income you have declared (such as copies of child support, alimony, social security, or pension payments).
- If applicable, a letter and supporting documentation explaining any unusual employment or household circumstances and any other income received since the beginning of the current year (for example: bonus, inheritance etc.).
- A no-income-statement, signed and notarized, for any household member over 18 who has no source of income.

Special Unit Requirements Questionnaire

THIS QUESTIONNAIRE IS USED TO DETERMINE WHETHER AN APPLICANT NEEDS SPECIAL FEATURES IN THEIR HOUSING UNIT. THE NEED FOR SPECIAL ADAPTIONS MUST BE VERIFIED IN ORDER TO ASSURE THAT THE PROPER UNITS WITH SPECIAL FEATURES GO TO APPLICANTS THAT ACTUALLY NEED THE FEATURES.

APPLICANTS NAME: _____ FILE #: _____

DATE: _____ I CHOOSE NOT TO COMPLETE THIS FORM: _____

APPLICANTS SIGNATURE: _____

_____

1. DO YOU HAVE A CONDITION THAT REQUIRES':

   FIRST FLOOR UNIT: _____ BARRIER FREE UNIT: _____

   UNIT FOR VISION IMPAIRED: _____ UNIT FOR HEARING IMPAIRED: _____

   OTHER: _____

2. CAN YOU GO UP AND DOWN STAIRS UNASSISTED?

   YES ____ NO ____

3. CAN YOU OPERATE AN ELEVATOR UNASSISTED?

   YES ____ NO ____

   WILL YOU REQUIRE AN AID TO ASSIST YOU?

   YES ____ NO ____

IF YOU CHECKED YES FOR ANY OF THE ABOVE LISTED CATEGORIES, PLEASE EXPLAIN EXACTLY WHAT YOU NEED TO ACCOMMODATE YOUR SITUATION.

_____

_____

_____

Who should be contacted to verify your need for the feature's you have identified above?

NAME _____ TEL # ( ) _____

ADDRESS _____

CITY/TOWN _____ STATE _____

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
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Advocates, Inc. Application for Services

1. IDENTIFYING INFORMATION

Participant Name: _____ Tel #: ( )_____

Present
Address _____ City: _____ State: ____ Zip: _____

Diagnosis: _____

Functional Limitations:_____

_____

_____

_____

_____

_____

_____

Current Living Arrangements: Alone ( ) With Others ( ) Other:_____

_____

_____

_____

If living with others, please describe living situation and care needed: _____

_____

_____

Marital Status: (Circle one) S M W D Sep. Sex: M F Birthdate:_____/_____/_____

Total Monthly Income: _____ Medicaid Card #:_____

Social Security #: _____ Medicare #: _____

Other Insurance Specify with policy #'s: _____

Subscriber:_____

_____

2. CONTACT INFORMATION

A. Emergency Contact: _____ Tel #: (____) _____

Address: _____ Relationship: _____

B. Emergency Contact: _____ Tel #: (____) _____

Address: _____ Relationship: _____

C. Case Manager: _____ Agency: _____

Address: _____ Tel #: (____) _____

D. Guardian: _____ Tel #: (____) _____

Address: _____

Referred by: _____ Title: _____ Tel #: (____) _____

Address: _____

E. Mass Rehabilitation Counselor: _____ Tel #: (____) _____

Address: _____

Comments: _____

3. MEDICAL INFORMATION

Primary Care Physician: _____ Tel #: (____) _____

Address: _____

Date of Last Physical: _____

Present Hospital Affiliation: _____

INPATIENT HOSPITALIZATION HISTORY (USE ADDITONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Admission Date	Discharge Date

OUTPATIENT SERVICES HISTORY (USE ADDITIONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Therapies Used: Physical, Occupational, Speech, Neuropsychological, Psychological, Other… (pleas specify)	Discharge Date

NURSING HOME, LONG TERM CARE, MENTAL HEALTH FACILITY HISTORY

Admission Date	Facility	Reason for Admission	Discharge Date

MEDICATION SCHEDULE

Medication	Dosage	Purpose	Prescribing Physician	Date Started

Names of other physicians involved with their telephone number:

Neurologist:_____Tel #:_( )_____

Neurosurgeon:_____Tel #: ( )_____

Psychiatrist:_____Tel #:_( )_____

Other physicians involved in your care: _____

_____

_____

_____

_____

Allergies: _____

_____

Any other significant illness or injuries: _____

_____

4. ASSISTANCE IN HOME

Certified Home Health Agency currently using: _____

Address: _____ Tel #: ( )_____

Nurse ( ) Frequency: _____

Home Health Aid ( ) Frequency: _____

Homemaker ( ) Frequency: _____

Personal Care Assistant ( ): _____

Other services needed: _____

Special Equipment being used: _____

Other (describe): _____

_____

Signature of person filling out this application: _____

Printed name of person filling out this application: _____

Signature of applicant: _____

Printed name of applicant: _____

Date: _____

Advocates, Inc.

1 Clarks Hill, Suite 305
Framingham, MA 01702

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
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AUTHORIZATION FORM
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name:_____ **DOB**:_____

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information designated below between:

Staff at Warren House, McLaughlin House, Douglas House or Old Farm Rockport Clinician/Staff or Advocates staff at Advocates, Inc. 1 Clarks Hill, Suite 305, Framingham, MA 01702

And the following person / Organization:

Supportive Living, Inc. (SLI)
Print Name

400 West Cummings Park, Suite 6100, Woburn, MA 01801
Print Address

Health information includes information collected from me or created by the above Providers, or information received by the above Providers from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I further understand that Advocates and its employees are prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2).

I further understand that under state law Advocates and its employees are prohibited from disclosing information about my HIV status without my specific written authorization. Advocates and its employees are also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed consent," except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

Check appropriate boxes:

Health Information that may be used or disclosed through this Authorization is as follows:

_X_ All health information about me, including my clinical records, created or received by Advocates or any of its employees and the above listed Provider/Organization. This information may include, if applicable:

____ Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse; Specifically for the following purpose(s)_____

____ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.
Specifically for the following purpose(s)_____

____ Information regarding the results of a genetic test.

- Specific information including only: _____
_____
_____
_____

This Authorization expires: upon discharge from the program
(Insert applicable event or date – mm/dd/yy)

(Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure).

1. I understand that Advocates and its employees cannot guarantee that PHI disclosed to the above indicated Person/Organization will not be re-disclosed to a third party. The Person/Organization may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the Person/Organization is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Advocates, Inc, except when (i) my refusal may limit Advocates ability to provide safe and effective care (ii) I am receiving research-related treatment or (iii) receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Advocates or its employees in reliance on this Authorization before written notice of revocation is received by Advocates or its employees. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Advocates, Inc. 27 Hollis St., Framingham, MA 01702

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:_____ Date of signature:_____

Print Client's full name:_____

Client's Home Address:_____

Client's Home Telephone:_____ Date of Birth:_____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative:_____ Date of signature:_____

Print name:_____

Relationship of representative to client:_____

AGENCY CODE: XSLIVI
FEE EXEMPTION CODE: FE411

Supportive Living, Inc.

CORI REQUEST FORM

Supportive Living Inc. (SLI) has been certified by the Criminal History Systems Board for access to Criminal Offender Record Information (CORI) pursuant to M.G.L c. 6, Paragraph 172(b) and/or 172(c). SLI has been granted access for the purpose of tenant selection only, and shall not be otherwise used or disseminated. **By signing below, I provide my consent to a CORI check and acknowledge that the information provided is true an accurate.**

Applicant/Employee Signature: _____ Date: _____

APPLICANT/EMPLOYEE SIGNATURE INFORMATION (PLEASE PRINT)

_____ _____ _____
Last Name First Name Middle Name

_____ _____
Maiden Name or Alias (if applicable) Place of Birth

_____ _____-_____
Date of Birth Last six digits of social security number

ID THEFT INDEX PIN (if applicable): _____

_____ _____
Mother's Full Maiden Name Father's Full Name

Current and Former Addresses:

_____

_____

_____

_____

Sex: _____ Height: ____ ft. ____in. Eye Color: _____ Race: _____

Driver's License Number or ID Number: _____ State of Issue: _____

*** THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM(S) OF GOVERNMENT ISSUED IDENTIFICATION:

_____
_____
_____

VERIFIED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

* The CHSB Identify Theft Index Pin Number is to be completed by those applicants that have been issued an Identify Theft Index Pin Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

STUDENT CERTIFICATION

Applicant: _____ Unit:_____

To be completed by each adult Applicant/Resident

Are you a student at an institution of higher education? _____Yes _____No

**Institutes of higher education include post-secondary vocational institutions; "proprietary institutions of higher education" which prepare students for "gainful employment in a recognized occupation," and accredited post-secondary colleges and universities. If you are not sure, please mark "yes" and we will verify it.*

If you have answered "no", please skip the following questions and sign below.

If you answered "yes", please complete the following questions:	**Yes**	**No**
1. Are you a full-time student?	_____	_____
2. Are you a graduate or professional student?	_____	_____
3. Are you at least 24 years of age?	_____	_____
4. Are you a veteran of the United States military?	_____	_____
5. Are you married?	_____	_____
6. Do you have a dependent child?	_____	_____
7. Do you have dependents other than a child or spouse?	_____	_____
8. Were you an orphan or a ward of the court through the age of 18?	_____	_____
9. Do you live with your parents?	_____	_____
If no:		
a. Are your parents receiving or eligible to receive Section 8 assistance?	_____	_____
b. Are you claimed as a dependent on your parent's tax return?	_____	_____
10. Are you receiving any financial assistance to pay for your education?	_____	_____

If you or another member of your household is determined to be an ineligible student now or in the future, you may not be eligible for assistance. If we determine at any time after move-in that you are ineligible for assistance, we will notify you by providing a 30-day notice that your assistance will be terminated. Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

_____ _____ _____

Signature of Applicant/Resident Printed Name of Applicant/Resident Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: Applicant/Tenant_____

Property Name: _____

Address: _____

I/We, the undersigned below hereby authorize all persons or companies in the categories listed below to release information regarding employment, income and/or assets for purposes of verifying information on my/our apartment rental application. I/We authorize release of information without liability to the owner/manager of the apartment community listed on the attached verification form and/or the State and Local Agencies/Department's service provider.

INFORMATION COVERED

I/We understand that previous or current information regarding me/us may be needed. Verifications and inquires that may be requested include, but are not limited to: personal identity, student status, employment, income assets, medical or child care allowances. I/We understand that this authorization cannot be used to obtain information about me/us that is not pertinent to my eligibility for and continued participation as a Qualified Tenant.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information include, but are not limited to:

Past and Present Employers
Support and Alimony Providers
State Unemployment Agencies
Banks and other Financial Institutions
Welfare Agencies
Educational Institutions
Social Security Administration
Previous Landlords (including Public Housing Agencies)
Veterans Administrations
Retirement Systems
Medical and Child Care Providers

CONDITIONS

I/We agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file and **will be valid for 15 months from my signature date**. **Everyone 18 years or age and older must sign this form.**

SIGNATURES

_____	_____	_____
Signature of Applicant/Resident	Printed Applicant/Resident Name	Date
_____	_____	_____
Signature of CO/Applicant Resident	Printed Co/Applicant/Resident Name	Date
_____	_____	_____
Signature of Adult Member	Printed Adult Member Name	Date
_____	_____	_____
Signature of Adult Member	Printed Adult Member Name	Date

NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF A TAX RETURN IS NEEDED, IRS FORM 4506, "REQUEST FOR COPY OF A TAX FORM" MUST BE PREPARED AND SIGNED SEPARATELY