

APPLICATION FOR OCCUPANCY

Project name: \_\_\_\_\_

FOR OFFICE USE ONLY	
Date Received: _____	Time: _____

Size of Unit Requested:  1 BR  
 2 BR  
 3 BR

\*PLEASE COMPLETE ALL BLANKS OF THIS APPLICATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

**AN APPLICATION FEE OF \$ \_\_\_\_\_ IS REQUIRED TO ACCOMPANY THIS APPLICATION.**

**I. APPLICANT INFORMATION AND RESIDENCE HISTORY**

Applicant	Co-Applicant (if applicable)
Name: _____	Name: _____
Current Address: _____	Current Address: _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
Phone: Home _____ Work _____	Phone: Home _____ Work _____
How long have you resided at this address? _____	How long have you resided at this address? _____
Landlord's Name: _____	Landlord's Name: _____
Landlord's Address: _____	Landlord's Address: _____
Landlord's Phone No: _____	Landlord's Phone No: _____
Previous Address: _____	Previous Address: _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
How long have you resided at this address? _____	How long have you resided at this address? _____
Landlord's Name: _____	Landlord's Name: _____
Landlord's Address: _____	Landlord's Address: _____
Landlord's Phone No: _____	Landlord's Phone No: _____

**II. HOUSEHOLD MEMBER INFORMATION**

A. Provide the following information for all persons who will be members of the household.

Name	Social Security #	Gender	Date of Birth	Age	Full-Time Student (Y/N)

B. Does anyone else claim the Tenant or Co-Tenant as a dependent on their Income Tax Return? YES \_\_\_\_\_ NO \_\_\_\_\_

**III. SPECIAL HOUSING ACCOMMODATIONS**

A. Households where the tenant, co-tenant, or household member requires special accommodations due to a disability may qualify for a unit with special design features for accessibility, and/or an adjustment to income when calculating their rent payment.

- Do you or members of your household qualify for a unit with special design features?  Yes  No
- Are there any special housing requirements necessary?  Yes  No  
If Yes, please explain \_\_\_\_\_

- Do you request the adjustment to income?  Yes  No

B. The Tenant Selection Policy grants a priority to those tenant applicants that are a holder of a "Letter of Priority Entitlement" issued by the USDA Rural Development, and those households displaced due to housing being rendered uninhabitable.

- Do you hold a "Letter of Priority Entitlement"?  Yes  No



- Are you currently living in a housing unit that has been determined to be uninhabitable?  Yes  No  
If Yes, please explain:

IV. ESTIMATED HOUSEHOLD INCOME FOR THE NEXT 12 MONTHS

A. Employment Income

Applicant:

Employer Name	Address	Phone No.	Rate Per Hour	Hours per Week	Annual Income
_____	_____	_____	_____	_____	_____

How long have you been employed at this job? \_\_\_\_\_ Date you started this job \_\_\_\_\_  
How long have you been employed at this job? \_\_\_\_\_ Date you started this job \_\_\_\_\_

Co-Applicant:

Employer Name	Address	Phone No.	Rate Per Hour	Hours per Week	Annual Income
_____	_____	_____	_____	_____	_____

How long have you been employed at this job? \_\_\_\_\_ Date you started this job \_\_\_\_\_  
How long have you been employed at this job? \_\_\_\_\_ Date you started this job \_\_\_\_\_

B. Other Income

Source	Explanation	Annual Amount (Applicant)	Annual Amount (Co-Applicant)
Social Security			
Supplemental Social Security			
Welfare (ADC)			
Child Support/Alimony			
Unemployment Benefits			
Disability Benefits			
Pensions			
401-K annual income			
Bank Interest			
Income from Assets			
Other			
<b>TOTAL</b>			

Does the Tenant or Co-Tenant regularly receive gifts of money, food, clothing, utilities, etc. from any source? YES \_\_\_ NO \_\_\_  
IF YES complete and attach Guide 335 "Statement of Gifts Received by the Family".

**NO INCOME** – If you claim to have no income, complete and attach Guide 339b "Certification of Zero Income".

C. Deductible Family Expenses

Expense	Annual Amount
Child Care – If you have child care, complete and attach Guide 337a "Verification of Child Care Expense"	\$ _____
Projected Medical Expenses for 12 month period (Elderly & Handicapped Only) Complete and attach Guide 352 "Medical Expense Projections"	\$ _____
Handicap care or apparatus expenses	\$ _____



V. ASSETS

A. List assets for all household members.

Asset	\$ Amount	Account #	Financial Institution Name & Address
Cash on hand			
Checking Accounts	_____	_____	_____
Savings Accounts	_____	_____	_____
Money Market Certificates/CD's	_____	_____	_____
IRA's			
Pensions or 401-K's			
Revocable Trusts			
Stocks	_____	_____	_____
Bonds (any type)	_____	_____	_____
Life Ins. (cash value)	_____	_____	_____
Other			
Other			

B. List Real Estate Owned by any member of the household.

Description of Real Estate	Value	Debt
	\$	\$
	\$	\$

C. List all assets disposed of for less than FAIR MARKET VALUE during the two years proceeding the effective date of this certification or re-certification.

Item	Date Disposed of	Fair Market Value	Sales Price	Fair Market Value – Sales Price
		\$	\$	\$
		\$	\$	\$

VII. CREDIT REFERENCES

Lending Institution	Address	Account #

VII. OTHER INFORMATION

- A. Have you ever received housing assistance from the Department of Housing and Urban Development or USDA Rural Development?  
 Yes  No  
 • If Yes, has your family's assistance or tenancy in a subsidized housing program ever been terminated for fraud, non-payment of rent, or failure to cooperate with re-certification procedures?  Yes  No
- B. Are you or any other household member a current user or been convicted of using, dealing, or manufacturing a controlled substance?  
 Yes  No  
 • If Yes, has that person(s) successfully completed a controlled substance abuse recovery program or presently enrolled in such a program?  Yes  No
- C. Have you or any members of the household been convicted of a felony?  Yes  No  
 If Yes, please explain circumstances: \_\_\_\_\_
- D. How did you learn about the apartments?  
 Newspaper  Radio  Drive-by  Resident Referral  Other \_\_\_\_\_



VIII. EMERGENCY CONTACT(s):

In case of an emergency the Tenant or Co-Tenants desire that the following persons be contacted if possible:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

IX. SIGNATURE AND CONSENT

I certify that the housing that I am applying for will be my permanent residence and I will not maintain a separate subsidized rental unit in a different location. I declare that the statements contained in this application are true and complete to the best of my knowledge. I hereby authorize release of any information contained herewith to determine my eligibility for this housing. **WARNING: WILLFUL FALSE STATEMENTS OR MISREPRESENTATION ARE A CRIMINAL OFFENSE UNDER SECTION 1001 OF TITLE 18 OF THE U.S. CODE. NOTE: USDA RURAL DEVELOPMENT (FORMERLY FmHA) IN NEBRASKA HAS AN AGREEMENT WITH THE DEPARTMENT OF LABOR TO PROVIDE WAGE MATCHING INFORMATION FOR THE PURPOSE OF DETECTION OF FRAUDULENT STATEMENTS REGARDING INCOME.**

The information regarding race, ethnicity, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the Rural Housing Service that the Federal laws prohibiting discrimination against tenant applications on the basis of race, color, national origin, religion, sex, familial status, age, and disability are complied with. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, the owner is required to note the race, ethnicity, and sex of individual applicants on the basis of visual observation or surname.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

C0-Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- |                       |  |   |  |
|-----------------------|--|---|--|
| Race: (Optional)      | <input type="checkbox"/> American Indian or Alaska Native          | <input type="checkbox"/> Asian                  | <input type="checkbox"/> Black or African American |
|                       | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> White                  |  |
| Ethnicity: (Optional) | <input type="checkbox"/> Hispanic or Latino                        | <input type="checkbox"/> Not Hispanic or Latino |  |
| Race: (Optional)      | <input type="checkbox"/> American Indian or Alaska Native          | <input type="checkbox"/> Asian                  | <input type="checkbox"/> Black or African American |
|                       | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> White                  |  |
| Ethnicity: (Optional) | <input type="checkbox"/> Hispanic or Latino                        | <input type="checkbox"/> Not Hispanic or Latino |  |

“This institution is an equal opportunity provider.”

