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| FOR OFFICE USE ONLY DATE RECEIVED _____ TIME RECEIVED _____ |
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**WINDSOR HOUSING COMPANY I (OWNERS)
 SEPP MANAGEMENT COMPANY INC. (MANAGING AGENTS)
 53 FRONT STREET
 BINGHAMTON, NY 13905**

**PLEASE RETURN THIS APPLICATION TO:
 WINDSOR WOODS
 49 GROVE STREET
 WINDSOR, NY 13865
 TELEPHONE: 607-655-4191 TDD # 607-723-0438**

PLEASE NOTE: WINDSOR WOODS APARTMENTS IS A 100% SMOKE FREE FACILITY!!

Please respond to questions on this form as appropriate. If application is for two (2) persons (a couple is considered two (2) persons), please be sure to complete both columns where answers are applicable. If you need assistance in filling out this application, please call our office.

Please review your application carefully. If any questions are not answered, the application may be deemed to be incomplete and could be returned to you.

APPLICANT #1

APPLICANT #2

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

CITY/TOWN _____

CITY/TOWN _____

STATE _____ **ZIP CODE** _____

STATE _____ **ZIP CODE** _____

TELEPHONE NUMBER _____

TELEPHONE NUMBER _____

EMAIL ADDRESS: _____

EMAIL ADDRESS: _____

Age _____ **Date of Birth** ___/___/___

Age _____ **Date of Birth** ___/___/___

Social Security # _____

Social Security # _____

If two (2) persons are applying, what is your relationship, if any, to the other applicant?

Name of another person whom we can contact if you are not available:

Name _____

Address _____ **City** _____ **State & Zip Code** _____

Telephone Number _____

PRESENT INCOME

Applicant #1

Applicant #2

| | | |
|---------------------------------------|----------|----------|
| Gross Monthly Social Security Payment | \$ _____ | \$ _____ |
| Monthly Supplemental Security Payment | \$ _____ | \$ _____ |
| Monthly Pension Income | \$ _____ | \$ _____ |
| Gross Monthly Employment Income | \$ _____ | \$ _____ |
| Other Income | \$ _____ | \$ _____ |

PRESENT ASSETS

| | | |
|---|----------|----------|
| Full Value of Any Stocks | \$ _____ | \$ _____ |
| Full Value of Any Bonds | \$ _____ | \$ _____ |
| Full Value of Any Certificates of Deposit | \$ _____ | \$ _____ |
| Market Value of Any Owned Real Estate | \$ _____ | \$ _____ |
| Full Value of Any Other Assets | \$ _____ | \$ _____ |

CURRENT BANK ACCOUNT BALANCES

| | | |
|--------------|----------|----------|
| Checking | \$ _____ | \$ _____ |
| Savings | \$ _____ | \$ _____ |
| Money Market | \$ _____ | \$ _____ |
| Other | \$ _____ | \$ _____ |

PRESENT LIVING ACCOMMODATIONS

(please check as appropriate)

| | | |
|----------------------------------|-------|-------|
| Own House or Mobile Home | _____ | _____ |
| Rental Housing | _____ | _____ |
| Hotel | _____ | _____ |
| Boarding House | _____ | _____ |
| Living with a Friend | _____ | _____ |
| Living with a Relative | _____ | _____ |
| Licensed or Supervised Residence | _____ | _____ |

How long have you lived at current address? _____

What is your current monthly rent or lodging? \$ _____

Does your rent include utilities? Yes _____ No _____

If your rent does not include utilities, what is the approximate average cost per month for utilities, not including telephone or television cable? \$ _____

Are you presently receiving any form of rental assistance or rent subsidy? Yes _____ No _____

If Yes, What is the Source? _____ What is the amount? \$ _____

How did you hear about Windsor Woods? Newspaper ad _____ TV _____ Radio _____

Referred by Agency _____ Web Site _____ Other (identify) _____

The Rural Development requires the Owner, or their Representative, to determine initial applicant eligibility on the basis of an Annual Adjusted Income, rather than on Gross Income. Please provide the following:

ANTICIPATED MEDICAL EXPENDITURES FOR THE NEXT TWELVE (12) MONTHS

| | Applicant #1 | Applicant #2 |
|---|--------------|--------------|
| Medicare | \$ _____ | \$ _____ |
| Other Medical Insurance Premiums | \$ _____ | \$ _____ |
| Prescriptions/Non-Prescriptions | \$ _____ | \$ _____ |
| Services of Physicians NOT covered by Insurance | \$ _____ | \$ _____ |
| Medicaid spend down | \$ _____ | \$ _____ |
| Dental Costs | \$ _____ | \$ _____ |
| Hearing Aid Batteries | \$ _____ | \$ _____ |
| Attendant Care Costs | \$ _____ | \$ _____ |
| Payments on Accumulated Medical Bills | \$ _____ | \$ _____ |
| Other (specify) _____ | \$ _____ | \$ _____ |

YOU MAY BE ELIGIBLE FOR A \$400 DEDUCTION, IF YOU MEET THE DEFINITION OF “ELDERLY HOUSEHOLD.”

“AN ELDERLY HOUSEHOLD IS A HOUSEHOLD WHERE THE TENANT, CO-TENANT, MEMBER OR CO-MEMBER IS AT LEAST 62 YEARS OF AGE OR IS DISABLED OR HANDICAPPED REGARDLESS OF AGE”

DO YOU WISH TO CLAIM THE \$400 ALLOWANCE? ___ YES ___ NO

IF YOU ANSWERED YES PLEASE ANSWER THE FOLLOWING:

DO YOU WISH A HANDICAP ACCESSIBLE UNIT? ___ YES ___ NO

IF YOU ANSWERED YES, YOU WILL BE REQUIRED TO PROVIDE EVIDENCE OF YOUR HANDICAP OR DISABILITY.

DO YOU DRIVE?_ ___ YES ___ NO DO YOU OWN A CAR? ___ YES ___ NO

DO YOU USE PUBLIC TRANSPORTATION? ___ YES ___ NO

**DO YOU PERFORM ANY VOLUNTEER OR COMMUNITY SERVICE ACTIVITIES?
___ YES ___ NO IF YES, PLEASE BRIEFLY DESCRIBE:**

SUPPORTIVE ASSISTANCE

IF YOU RECEIVE REGULAR INCOME, OTHER THAN THE INCOME LISTED ON PAGE 2 OF THIS APPLICATION FROM FAMILY MEMBERS OR ANYONE ELSE; PLEASE PROVIDE THE NAME; ADDRESS; TELEPHONE NUMBER OF SUCH INDIVIDUALS; THE RELATIONSHIP TO YOU AND THE DOLLAR AMOUNT RECEIVED. (REGULAR ASSISTANCE IS ANY MONEY YOU RECEIVE WEEKLY, MONTHLY, OR ANNUALLY FROM THESE INDIVIDUALS).

- 1. _____ \$ _____
- 2. _____ \$ _____
- 3. _____ \$ _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS APPLICATION

I CERTIFY THAT UPON OCCUPANCY I WILL MAINTAIN THE UNIT AS MY PERMANENT RESIDENCE AND WILL NOT AND DO NOT MAINTAIN ANOTHER RENTAL UNIT. ANY WILLFUL MISREPRESENTATION OR CONCEALMENT OF ANY MATERIAL FACT WHICH WOULD REFLECT ELIGIBILITY FOR ADMISSION WILL BE CONSIDERED GROUNDS FOR TERMINATION OF LEASE AND EVICTION. I, THEREFORE, DECLARE THE INFORMATION PROVIDED TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant #1 Signature

Applicant #2 Signature

Date ____ / ____ / ____

Date ____ / ____ / ____

IF ASSISTANCE WAS OBTAINED IN FILLING OUT THIS APPLICATION, PLEASE PROVIDE THE FOLLOWING INFORMATION ON THE ASSISTANT:

Name _____

Address _____

Telephone _____ Date ____ / ____ / ____

Signature _____

THE INFORMATION REGARDING RACE, NATIONAL ORIGIN AND SEX SOLICITED BELOW ON THIS APPLICATION IS REQUESTED BY THE APARTMENT OWNER IN ORDER TO ASSURE THE FEDERAL AND STATE GOVERNMENT THAT FEDERAL LAWS PROHIBITING DISCRIMINATION AGAINST TENANT APPLICATIONS ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, RELIGION, SEX, FAMILIAL STATUS, AGE AND HANDICAP ARE COMPLIED WITH. YOU ARE NOT REQUIRED TO FURNISH THIS INFORMATION, BUT ARE ENCOURAGED TO DO SO. THE 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 OR ITS AGENT IS REQUIRED TO NOTE THE RACE, NATIONAL ORIGIN AND SEX OF INDIVIDUAL APPLICANTS ON THE BASIS OF VISUAL OBSERVATION OF SURNAME, AND PERSONAL INTERVIEWS. CONSEQUENTLY, WE WOULD APPRECIATE YOUR VOLUNTARY ANSWER TO THE FOLLOWING QUESTIONS:

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Race: (Mark one or more) White _____ Black or African American _____ Spanish American _____ Asian _____
American Indian/Alaska Native _____ Native Hawaiian or Other Pacific Islander _____

Sex: Female _____ Male _____