Columbia Cascade Housing Corporation

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Equal Housing Opportunity.
"This institution is an Equal Opportunity Provider"

MOSIER CREEK APARTMENTS
RENTAL APPLICATION

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NOTICE TO APPLICANT:

PLEASE FILL OUT THIS APPLICATION COMPLETELY AND RETURN IT TO COLUMBIA CASCADE HOUSING. ALL BLANKS MUST BE FILLED IN BEFORE THE APPLICATION WILL BE CONSIDERED COMPLETE AND CAN BE PROCESSED FOR ELIGIBILITY. IF THE BLANK DOES NOT APPLY TO YOUR SITUATION, PUT N/A IN THE BLANK. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH SEPARATE SHEET (S) WITH REQUESTED INFORMATION.

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APPLICANTS FULL LEGAL NAME AND CURRENT MAILING ADDRESS		
NAME	ADDRESS	APT
CITY	STATE	ZIP
CURRENT PHONE OR MESSAGE NUMBER ( )		

NAME OF PRESENT LANDLORD________________________ PHONE________________
ADDRESS OF LANDLORD____
LENGTH OF RESIDENCY________________________ MONTHLY RENT____________
REASON FOR MOVING____

PREVIOUS LANDLORD'S NAME________________________ PHONE________________
PREVIOUS LANDLORD'S ADDRESS____
LENGTH OF RESIDENCY____________ ADDRESS OF RESIDENCY_________________
CITY________________________ STATE__________ ZIP__________

LIST ALL PERSONS WHO WILL RESIDE IN YOUR HOUSEHOLD (STARTING WITH YOURSELF). Please Print LAST NAME FIRST MI	SOCIAL SECURITY NUMBER	RELATION TO APPLICANT	DATE OF BIRTH	AGE
① APPLICANT				
② CO-APPLICANT				
③				
④				

WOULD ANYONE IN YOUR HOUSEHOLD BENEFIT FROM A SPECIAL HANDICAP UNIT? ☐ YES ☐ NO
IF YES, PLEASE SPECIFY TYPE OF UNIT REQUIRED__________________________

HAVE YOU EVER LIVED IN A FmHA OR HUD PROJECT ☐ YES ☐ NO
IF SO, WHERE?____

DO YOU WISH A CASEWORKER OR ANOTHER INDIVIDUAL TO BE NOTIFIED WHEN YOU ARE CONTACTED FOR ASSISTANCE? ☐ YES ☐ NO IF YES: NAME OF CASE WORKER OR CONTACT PERSON__________
NAME OF AGENCY____
ADDRESS________________________ CITY______________ STATE________ZIP________

SOURCE OF INCOME:

LIST ALL INCOME SOURCES. THIS INCLUDES, BUT IS NOT LIMITED TO, FULL AND/OR PART-TIME EMPLOYMENT, ALL INCOME FROM WELFARE AGENCIES, SOCIAL SECURITY, PENSIONS, SSI, DISABILITY, ARMED FORCES RESERVES, UNEMPLOYMENT COMPENSATION, CHILD CARE, ALIMONY, CHILD SUPPORT, STUDENT GRANTS, CONTRACT FOR DEED, INTEREST ON ASSETS, DIVIDENDS, ANNUITIES, REGULAR CONTRIBUTIONS FROM PEOPLE NOT RESIDING WITH YOU.

(PLEASE ATTACH A COPY OF YOUR TAX RETURN FOR PREVIOUS YEAR)

NAME OF PERSON IN HOUSEHOLD WITH INCOME	LIST OF NAME & ADDRESS OF THE SOURCE OF INCOME. (BANK, EMPLOYER AGENCY , SSA, SSI ETC.)	AMOUNT OF **GROSS** INCOME MONTHLY	ANNUALLY
	_____	$	$
	_____	$	$
	_____	$	$
	_____	$	$

ASSETS (PLEASE LIST ALL ASSETS, SUCH AS SAVINGS OR CHECKING ACCOUNTS, TRUST ACCOUNTS, SAVINGS BONDS, STOCKS OR BONDS, AND LIFE INSURANCE.)

NAME OF BANK OR ESTABLISHMENT (PLEASE LIST ADDRESS)	**ACCOUNT, POLICY OR CERTIFICATE NUMBER**	**BALANCE OR VALUE**
_____		**$**
_____		**$**
_____		**$**
_____		**$**
LIFE INSURANCE AGENT:		**$**
SAVINGS BONDS LOCATION:		**$**
STOCKS OR BONDS LOCATION:		**$**

DO YOU OWN ANY STOCKS OR BONDS? ❒ YES ❒ NO, LIFE INSURANCE? ❒ YES ❒ NO
ANY SAVINGS BONDS? ❒ YES ❒ NO (IF YES TO ANY, PLEASE LIST ABOVE.)

REAL PROPERTY--DO YOU OWN ANY PROPERTY? ❒ YES ❒ NO
IF YES, **TYPE OF PROPERTY**_____
LOCATION_____
APPRAISED MARKET VALUE?_____

HAVE YOU SOLD OR DISPOSED OF ANY PROPERTY OR ASSETS IN THE LAST TWO YEARS?
❒ YES ❒ NO IF YES, GIVE **TYPE OF ASSET AND DATE SOLD/DISPOSED OF**
TYPE_____ DATE_____
AMOUNT RECEIVED FROM ASSET_____

DO YOU HAVE ANY OTHER ASSETS NOT LISTED ABOVE (EXCLUDING HOUSEHOLD GOODS)?
IF YES, GIVE TYPE AND VALUE : TYPE_____ VALUE_____

DEDUCTIONS

DOES ANYONE IN THE HOUSEHOLD REQUEST A HANDICAP/DISABILITY ADJUSTMENT TO INCOME? ❒ YES ❒ NO NOTE: *HANDICAP ASSISTANCE INCLUDES REASONABLE ATTENDANT CARE AND AUXILIARY APPARATUS EXPENSES TO THE EXTENT NEEDED TO ENABLE ANY FAMILY MEMBER TO BE EMPLOYED.*

MEDICAL

PLEASE LIST THE AMOUNT OF ANTICIPATED EXPENSES OF HOSPITAL, MEDICAL, DENTAL, OPTICAL, AND INSURANCE (MEDICAL ONLY) FOR THE NEXT 12 MONTHS.

NOTE: *THIS DEDUCTION IS ALLOWED ONLY IF APPLICANT OR CO-APPLICANT IS ELDERLY (62 YEARS OR OLDER) OR DISABLED OR HANDICAPPED.*

MEDICAL EXPENSES ***DO NOT INCLUDE EXPENSES COVERED BY MEDICARE OR INSURANCE***

NAME OF FACILITY AND ADDRESS WHERE YOU RECEIVE MEDICAL SERVICES IF NEEDED, ATTACH ADDITIONAL SHEETS TO THIS APPLICATION	TYPE (MEDICAL, DENTAL, HOSPITAL)	YEARLY ESTIMATE OF EXPENSES
_____		
_____		
_____		
MEDICAL INSURANCE NAME:	POLICY NUMBER	

PHARMACY EXPENSES *PLEASE GIVE THE AMOUNT OF ANTICIPATED PRESCRIPTIONS AND NON-PRESCRIPTION EXPENSES PRESCRIBED BY A DOCTOR*

NAME OF PHARMACY	ADDRESS	YEARLY ESTIMATE OF EXPENSE
		$
		$
		$

OTHER DEDUCTIONS

IS ANYONE IN THE HOUSEHOLD A **FULL-TIME STUDENT** AND 18 YEARS OF AGE OR OLDER, BUT WHO IS NOT THE APPLICANT OR CO-APPLICANT? ❒ YES ❒ NO

NOTE: *TO BE CONSIDERED A STUDENT, SHE/HE MUST CARRY A SUBJECT LOAD CONSIDERED FULL-TIME BY THE EDUCATIONAL INSTITUTION ATTENDED.*

DOES ANYONE REQUEST ADJUSTMENT TO INCOME DUE TO PAYMENT OF **CHILD CARE** WHICH ENABLES THEM TO WORK? ❒ YES ❒ NO

NOTE: *THE AMOUNTS PAID BY THE HOUSEHOLD FOR THE CARE OF MINORS UNDER 13 YEARS OF AGE MAY BE DEDUCTED ONLY TO THE EXTENT SUCH EXPENSES ARE NOT REIMBURSED. DEDUCTIONS FOR THESE EXPENSES ARE PERMITTED ONLY WHEN SUCH CARE IS NECESSARY TO ENABLE HOUSEHOLD MEMBER TO FURTHER HER OR HIS EDUCATION OR TO BE GAINFULLY EMPLOYED.*

EXPECTED ANNUAL EXPENSE $_____

IF YES, PLEASE GIVE COMPLETE NAME, AND ADDRESS OF CHILD CARE PROVIDER

_____

TELEPHONE NUMBER_____

PERSONAL REFERENCES (PLEASE LIST 3 PERSONS NOT RELATED OR LIVING WITH YOU WHOM YOU HAVE KNOWN FOR ONE YEAR.)

NAME	ADDRESS	PHONE #

NEAREST LIVING RELATIVE OR FRIEND WE CAN CONTACT IN EVENT OF AN EMERGENCY:
NAME_____
ADDRESS_____ PHONE_____

CREDIT REFERENCES

NAME	ADDRESS	ACCOUNT #

AUTOMOBILES

MAKE OR MODEL	YEAR	LIC.#	STATE

1. DO YOU HAVE ANY PETS? ❒YES ❒NO IF YES, SPECIFY TYPE OF PET_____
2. DO YOU HAVE A WATERBED? ❒YES ❒ NO IF YES , DO YOU HAVE INSURANCE? ❒YES ❒ NO
3. ARE YOU OR A MEMBER OF YOUR HOUSEHOLD A CURRENT ILLEGAL USER/DISTRIBUTOR OF A CONTROLLED SUBSTANCE? ❒YES ❒NO
4. HAVE YOU OR A MEMBER OF YOUR HOUSEHOLD BEEN CONVICTED OF THE ILLEGAL USE OF A CONTROLLED SUBSTANCE ? ❒YES ❒NO
5. HAVE YOU OR A MEMBER OF YOUR HOUSEHOLD BEEN CONVICTED OF THE ILLEGAL MANUFACTURE OR DISTRIBUTION OF A CONTROLLED SUBSTANCE? ❒YES ❒NO
6. IF YOU ANSWERED YES TO QUESTIONS 3, 4, OR 5 ABOVE, HAS THE PERSON SUCCESSFULLY COMPLETED A CONTROLLED SUBSTANCE ABUSE RECOVERY PROGRAM OR IS THE PERSON PRESENTLY ENROLLED IN SUCH A PROGRAM? ❒YES ❒NO
7. HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN CONVICTED OF A FELONY? ❒YES ❒ NO

FAILURE TO COMPLETE THIS APPLICATION FULLY OR GIVING FALSE INFORMATION MAY RESULT IN THIS APPLICATION BEING REFUSED OR EVICTION AFTER TENANCY.

APPLICANT AND/OR CO-APPLICANT HEREBY CERTIFIES THAT THIS APARTMENT WILL BE THEIR PERMANENT RESIDENCE AND THAT THEY WILL NOT MAINTAIN A SEPARATE SUBSIDIZED RENTAL UNIT IN A DIFFERENT LOCATION.

I AGREE TO GIVE THE OWNER OR OWNER'S REPRESENTATIVE THE AUTHORITY TO INVESTIGATE AND OBTAIN MY CREDIT RATING, MY CURRENT AND PAST RENTAL RECORDS, MY EMPLOYMENT HISTORY, ANY SOURCES OF INCOME TO MY HOUSEHOLD, MY CURRENT/PAST UTILITY RECORDS, AND ANY INFORMATION NECESSARY TO DETERMINE MY ELIGIBILITY. THE INFORMATION OBTAINED WILL BE USED FOR MANAGEMENT PURPOSES ONLY AND WILL BE HELD IN CONFIDENCE. DUE TO CHANGES IN CIRCUMSTANCES ADDITIONAL INFORMATION MAY BE REQUESTED AT A LATER DATE TO COMPLETE THE PROCESSING OF THIS APPLICATION. YOUR SIGNATURE BELOW CERTIFIES THAT THE STATEMENTS MADE ON THIS APPLICATION ARE **TRUE** AND **CORRECT**, AND GIVES MANAGEMENT **CONSENT** TO VERIFY THE INFORMATION CONTAINED IN THIS APPLICATION. I/WE ACKNOWLEDGE THAT I MUST KEEP MANAGEMENT INFORMED OF MY CONTINUED INTEREST AT LEAST EVERY 90 DAYS.

APPLICANT'S
SIGNATURE__________________________________ DATE___________

CO-APPLICANTS
SIGNATURE____________________________ DATE_____________

☆WARNING☆ SECTION 1001 OF TITLE 18, UNITED STATES CODE PROVIDES, "WHOEVER, IN ANY MATTER WITHIN THE JURISDICTION OF ANY DEPARTMENT OR AGENCY OF THE UNITED STATES KNOWINGLY AND WILLFULLY FALSIFIES, CONCEALS OR COVERS UP BY ANY TRICK, SCHEME, OR DEVICE A MATERIAL FACT, OR MAKES ANY FALSE, FICTITIOUS OR FRAUDULENT STATEMENTS OR REPRESENTATIONS, OR MAKES OR USES ANY FALSE WRITING OR DOCUMENT KNOWING THE SAME TO CONTAIN ANY FALSE WRITING OR ENTRY SHALL BE FINED NOT MORE THAN $10,000 OR IMPRISONED NOT MORE THAN FIVE YEARS, OR BOTH"

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<u>APPLICANT PLEASE READ:</u>

THE INFORMATION REGARDING RACE, NATIONAL ORIGIN, AND SEX DESIGNATION SOLICITED ON THIS APPLICATION IS REQUESTED IN ORDER TO ASSURE THE FEDERAL GOVERNMENT THAT FEDERAL LAWS PROHIBITING DISCRIMINATION AGAINST TENANT APPLICANTS 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. 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/NATIONAL ORIGIN AND SEX OF INDIVIDUAL APPLICANTS ON THE BASIS OF VISUAL OBSERVATION OR SURNAME.

The following information is requested by the Federal Governmant in order to monirot compliance with Federal Laws prohibiting discrimination against applicants seeking to participate in the program. 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, we are required to note the arce/national origin of individual applicants on the basis of visiual observation or surname.

Ethnicity:
Hispanic *or Latino* _____
Not Hispanic or Latino _____

Race : (Mark one or more)
White _____ Black *or African American* _____
American Indian/Alaska Native _____ Asian _____
Native American or other Pacific Islander _____
Gender: Male _____ Female _____

OWNER/OWNER'S REPRESENTATIVE'S
SIGNATURE_____

DATE RECEIVED_____ TIME RECEIVED_____

ALL BEDROOM SIZES ELIGIBLE FOR_____