



Community Housing In Partnership

241 Moore Street • Hackensack, NJ 07601 • (201) 489-1345 • Fax: (201) 342-9339

Date: _____

Dear _____:

Attached is an application you requested for a room at:

Independence Hall

Please provide us with the following documentation, as incomplete applications will not be considered.

- Proof of Income (8 Consecutive Pay-stubs if you get paid weekly or 4 if you get paid biweekly, Social Security Award Letter, Disability Award Letter or **any** form of Income you receive)
- Photo ID
- Birth Certificate
- Social Security Card
- Verification of Disability
- Latest IRS Tax Return
- The last six months of bank statements for all accounts

Please note this application will not place your name on Englewood Housing waiting list; it is strictly for our Single Room Properties.

If you have any questions, you may contact me at 201-968-0200 ext 7023.

Sincerely,

Alba Velasquez
Administrative Assistant
Real Estate & Management

**89 James Street, Englewood, NJ
COMMUNITY HOUSING IN PARTNERSHIP, INC.**

89 James Street, Englewood, NJ
COMMUNITY HOUSING IN PARTNERSHIP, INC.

Application

I-APPLICANT INFORMATION

Provide the requested information for the applicant and co-applicant, if any, below. If something is not applicable, write "NA" in the space.

INFORMATION REQUIRED	APPLICANT	CO-APPLICANT
Name		
Social Security Number		
Birth Date		
Street Address		
City/State/Zip Code		
Home Telephone Number		
Alternate Phone Number		
****IF APPLICABLE****		
Social Security (yes or no)		
Pension (yes or no)		
Disability (yes or no)		
Public Assistance (yes or no)		
WORK HISTORY		
Work Telephone Number		
Employer Name		
Employer Address		
Employer's City/State/Zip Code		
Position or Title		
Dates of Employment		
# of Years in Line of Work		
Previous Employer		
Previous Position		
Previous Dates of Employment		
Are you a US Citizen?		
Are you a Registered Alien?		

2- HOUSEHOLD COMPOSITION

List the name, relation to applicant, date of birth, and sex for all household members who will occupy the affordable home on the chart below.

Name (First & Last)	Relation to Applicant	Birth Date	Male/Female
1.			
2.			
3.			
4.			
5.			
6.			

3- HOUSEHOLD INCOME

Indicates gross annual income for all non-dependent household members 18 years and over. Identify the source of the other income (child support, alimony, disability, public assistance, social security, pensions, etc.) below.

Income Source	Applicant
Salary or Wages	
Commissions/Bonus	
Second Job	
Other *	

* Source (s) and Recipients of Other Income:

4- HOUSEHOLD ASSETS

List the Bank Name, Account Number, Account Type (Checking, Saving, Money Market, CD), and balance for all assets on deposits at financial institutions:

Financial Institution	Account Number	Account Type	Balance

5-OTHER ASSETS

List the stocks, bonds, cash surrender value of life insurance, real estate owned, or other directly held liquid assets. Indicate the asset's current cash value and annual income generated by the asset.

Description of Asset	Current Value	Annual Income

6- LIABILITIES

List any outstanding installment, personal, auto, credit union, or student loans, credit cards, and alimony or child support payments. Indicate monthly payments, unpaid balances, and number of payments left.

Liability	Monthly Payments	Balance	#of Payments Left

7- CREDIT QUESTIONS

Check appropriate answers below. Explain, "yes" answers in space provided. A "yes" answer will not necessarily disqualify you.

Questions	Yes	No
1. Are there outstanding judgments against you?		
2. Have you declared bankruptcy in the past 7 years?		
3. Had you had property foreclosed upon?		
4. Are you parties to a lawsuit?		
5. Have you ever or do you currently own, Real Estate?		

Explanations of "yes" answers:

8- LANDLORD INFORMATION (For past two landlords)

Most Recent Landlord Name	
Street Address	
City/State/Zip Code	
Telephone Number	
Reason for Moving	
Previous Landlord Name	
Street Address	
City/State/Zip Code	
Telephone Number	
Reason for Leaving	

9- EMERGENCY CONTACT: (Relative or Friend)

Name	
Relationship	
Street Address	
City/State/Zip Code	
Home Telephone Number	
Work Telephone Number	

10- PHYSICIAN INFORMATION (Optional)

Doctor's Name	
Street Address	
City /State/Zip Code	
Telephone Number	

CERTIFICATION OF INFORMATION

I hereby certify all information I have provided on this application is true and accurate and authorize Community Housing In Partnership, Inc. to verify any information herein contained, check my credit history through a credit bureau, and use this information on reports to other organizations if my name is not mentioned.

Applicant's Signature

Date

BCCAP Residential
Intake/admission face sheet

room# _____

Admission date: _____ Residence: _____ Referred by: _____

First name: _____ Middle name: _____ Last name: _____

Date of Birth: _____ SS# _____ Age: _____ Sex: _____

Ethnicity /Race: _____ General Health: _____ medical status: _____

Previous Address: _____ Date you left this address: _____

Length of stay at previous residence: _____ what kind of residence was this? _____

Episodes of homelessness: _____ Housing status: _____ Homeless duration: _____

Homeless cause: _____ Have you ever been arrested: _____ How long was jail term: _____

Probation/parole: _____ (if yes) for how long: _____ drug of choice: _____

At what age did you begin using drugs: _____ Marital status: _____ Individual/family type: _____

Where are the children residing?: _____ Number of children: _____

Any Special needs: _____ General health: _____ Are you a victim of domestic violence: _____

Currently pregnant: _____ Due date: _____ health insurance carrier: _____

Currently employer: _____ Name of employer: _____

Address of employer _____ how long have you worked here _____

Number of hours worked last week: _____ full or part-time: _____ Monthly income: _____

Looking for work (if not currently employed) _____ highest level of education: _____

Post-secondary degree: _____ vocational training or apprenticeship certificate: _____

Veteran: _____ disabling condition: yes or no Birth place: _____

Citizen: _____ primary language: _____

Number you can be reached at: _____

Name and number of person to contact in cause of a emergency: _____

() _____

VERIFICATION OF DISABILITY

(Individual Claiming Disability)

The above named person is applying for participation in a federally-assisted housing program operated by the Bergen County Community Action Partnership, Inc. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the U. S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

- A. A person with a physical, mental or emotional impairment that:
1. Is expected to be of a long, continued and indefinite duration;
 2. Substantially impedes his or her ability to live independently; and
 3. Is of such a nature that such ability could be improved by more suitable housing conditions.

OR

- B. A severe chronic developmental disability which:
1. Is attributable to mental or physical impairment or combination of mental and impairments;
 2. Is manifested before the person attains age twenty-two;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and
 5. Reflects the person's need for a combination of and sequence of special, interdisciplinary, or generic care, a treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicated. (Please check the definition(s) that apply [] A; [] B; and describe your patient's condition:

Estimated duration that disability will continue: _____

Physician's Name: _____

Physician's License Number: _____

Address: _____

Telephone Number: _____

Physician's Signature: _____ Date: _____

Authorization of Release of Information Form

Name: _____

Address: _____

Social Security Number: _____

I, _____, authorizes CHIP, Inc. to obtain a consumer report, and any other such information deemed necessary for the purpose of evaluating my application/questionnaire. I understand such information may include, but is not limited to, credit history, civil and criminal information, records of arrest, rental history, employment history/salary details, vehicle records, licensing records, rental assistance, pension information, bank history, and other necessary information. I hereby expressly release CHIP, Inc. and any procurer or furnisher of information from liability what so ever in the use, procurement, or furnishing of such information and understand that my application information may be provided to various local, state and/or federal government agencies including without limitation, various law enforcement agencies.



Signature

Date

BANK ACCOUNT VERIFICATION

To: _____ From: Alba Velasquez – Administrative Assistant
 _____ Community Housing in Partnership
 _____ 241 Moore Street
 _____ Hackensack, New Jersey 07601

Applicant/Tenant/
 Dependant Minor: _____ Unit # _____
 Soc. Security #: _____

YOU DO NOT HAVE TO SIGN THIS FORM IF EITHER THE REQUESTING ORGANIZATION IS LEFT BLANK OR THE ORGANIZATION SUPPLYING THE INFORMATION IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is not older than 12 months. There are circumstances in which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature

Date

I. Checking Accounts:

Account #	Current Balance	Average 6 Month Balance	Interest Rate (N/A if no interest)	Date Closed
#	\$	\$	%	
#	\$	\$	%	
#	\$	\$	%	

II. Savings Accounts:

Account #	Current Balance	Interest Rate (N/A if no interest)	Date Closed
#	\$	%	
#	\$	%	
#	\$	%	
#	\$	%	
#	\$	%	

III. Certificates of Deposit:

Account #	Amount	Interest Rate	Date of Maturity	Early Withdrawal Penalty
#	\$	%		
#	\$	%		
#	\$	%		

AUTHORIZED SIGNATURE

Print Name: _____ Title: _____
Signature: _____ Date: _____
Telephone: _____

PENALTIES FOR MISUSING THIS CONSENT:

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 further 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.