
# CORTLAND ACRES HOUSING FOR THE ELDERLY
## DBA Pineview Apartments

# APPLICATION

Federal Program Guidelines for occupancy include person's age 62 or older, or disabled regardless of age. Are you applying as an applicant under one of these guidelines?

_____Yes _____No

*Persons with disabilities may request additional information.

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Name: _____

(Please Print)

Address: _____

City: _____State: _____Zip: _____

Telephone Number: _____Social Security No: _____

Date of Birth: _____Age: _____Marital Status: _____

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Co-Tenant's Name: _____

Address: _____

City: _____State: _____Zip: _____

Telephone Number: _____Social Security No: _____

Date of Birth: _____Age: _____Marital Status: _____

Please list All of the state where you (the applicant) and members of the household have resided in: _____

OCCUPANCY GUIDELINES for our one bedroom units are a minimum of one person and a maximum of two persons per apartment.

List below ALL of the people who will live in this apartment, other than the applicant, regardless of age if this application is approved:

Name: _____Relationship:_____

Social Security No: _____Date of Birth: _____

Will there be any change in familial composition within the next 12 months? __Yes__No
Are you or a dependent a full time student? _____Yes _____No
Are you or a dependent enrolled as a student in an institute 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 yes, please complete the attached student verification form.

## LANDLORD REFERENCE

Please complete the Landlord information for the last three (3) years.

**Present Landlord**: _____Telephone No: _____

Address: _____

Current Monthly Rent: _____Monthly Utility Costs: _____

How long have you lived at your present address: _____

**Previous Landlord:** _____Telephone No: _____

Address: _____

Rent Amount: _____Monthly Utility Costs: _____

Length of time lived at this address: _____

**Previous Landlord:** _____Telephone No: _____

Address: _____

Rent Amount: _____Monthly Utility Costs: _____

Length of time lived at this address: _____

## INCOME

The amount of rent you will pay depends upon the household's income. We are required to verify the annual amount of your income from all sources. Please complete information for each source.

1. Source of Income: _____
   Address: _____
   Amount: $_____per

2. Source of Income: _____
   Address: _____
   Amount: $ _____per

3. Source of Income: _____
   Address: _____
   Amount: $ _____per

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## ASSETS

Do you have any of the following?

**Checking Account:** ____Yes ____No; Name of Bank: _____

Address: _____City: _____State: _____Zip: _____

**Savings Account**: ___Yes ___No; Name of Bank: _____

Address: _____City: _____ State: _____Zip: _____

**Certificates of Deposit or IRA:** _____Yes ____No
Name of Bank or Institution: _____

Address: _____City: _____State: _____Zip: _____

**Do you OWN any of the following?**

**Land: ____Yes ___No** **Home**: ____Yes ____No **Mobile Home:** ____Yes ____No

If yes, at what value? _____
Where is the land, home and or mobile home located? _____
Have you disposed of any property in the past two (2) years? _____
If yes, at what value? _____
Where was the property located prior to sale, etc. _____
Have you disposed of any property in the last two (2) years at less than market value?
_____Yes _____No

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## MEDICAL INFORMATION

Under our program guidelines, we give an allowance for a percentage of anticipated medical expenses for the coming twelve months:

Physician's Name: _____ Address: _____

City: _____State: _____Zip: _____

Physician's Name: _____Address: _____

City: _____State: _____Zip: _____

Physician's Name: _____Address: _____

City: _____State: _____Zip: _____

Physician's Name: _____Address: _____

City: _____State: _____Zip: _____
Pharmacy's Name: _____

Address: _____City: _____

State: _____Zip: _____

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1. Are you receiving Medicare? _____Yes _____No
2. Are you receiving Medicaid? _____Yes _____No
3. Do you have other medical insurance, such as Blue Cross, AARP, etc. .
   ___Yes ___No
   Name of Company: _____
   Address: _____City: _____State: _____Zip: _____
4. What is the monthly premium amount? _____
5. Would the tenant or co-tenant benefit from the design feature of a mobility accessible adapted unit? ____Yes ____No
6. Do you/ co have unusually high recurring medical expenses not covered by medicare, Medicaid or private medical insurance? ____Yes ____No
   **If Yes**, Please Explain: _____
7. Are you or a member of your household currently an illegal abuser or addict of a controlled substance? _____Yes _____No
8. Have you or a member of your household been convicted of the illegal manufacture or distribution of a controlled substance or convicted for the illegal use of a controlled substance? _____Yes _____No
9. Are you or a member of your household subject to a lifetime state sex offender registration program in any state? _____Yes _____No
10. Will you or any member of your household need reasonable accommodations for rules, policies etc? _____Yes _____No

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**PERSONAL REFERENCES**
**(Individuals not related to you)**

Name: _____Address: _____

City: _____State: _____Zip: _____

Name: _____Address: _____

City: _____State: _____Zip: _____

## CREDIT REFERENCES

Name: _____Address: _____

City: _____State: _____Zip: _____

Name: _____Address: _____

City: _____State: _____Zip: _____

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## PET POLICY

Do you plan to have a pet living in your apartment? _____Yes _____No;
If yes, a pet deposit is required in the amount of $300, and all pets must abide by the pet policy guidelines.

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## EMERGENCY CONTACT

Please furnish the name, address and telephone number of a relative or friend whom we should contact in the case of an emergency:

Name: _____Address: _____

City: _____State: _____Zip: _____

Telephone Number: _____Relationship _____

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**DATE YOU DESIRE POSSESSION OF THE APARTMENT IF APPROVED:**

_____.

## SPECIAL NOTICE

"The information solicited on the application is requested by the apartment owner in order to assure the Federal Government, acting through the Department of Housing and Urban Development that federal laws prohibiting discrimination against tenant applicants on the basis of race, color, national origin, religion, sex, marital 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/national origin and sex of an individual applicant on the basis of visual observation or surname".

Race or Ethnic Group _____

Gender: _____Male _____Female

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"I UNDERSTAND that this is a preliminary application and gives no lease or rent rights. Additional information and a deposit will be required at a later date in order to complete the processing of my application".

_____ _____

**Applicant Signature** **Date**

_____ _____

**C0-Applicant Signature** **Date**

NOTE: All information is subject to verification by Cortland Acres For The Elderly dba Pineview Apartments prior to occupancy.

PLEASE RETURN COMPLETED APPLICATION TO:

Kelley Young
Apartment Manager
Pineview Apartments
39 Cortland Acres Lane
Thomas, WV 26292

Telephone Number 304 463-4181 Ext: 230
Fax Number 304 463-4190
TDD 1-800-982-8771

Management Use Only

Applicant Name _____ Date Received _____

Time Received _____ References Sent _____

References Completed _____ Date Interviewed _____

Action _____ Preference _____