

Mail this application to the address you
see at left.

Dear _____

I am applying to the following waitlist, which I believe is open:

App Generated:



ATTN: WAITLIST ADMINISTRATOR



Is this waitlist closed? Anything else you want to tell the 900 Housing Advocates and the nearly 200,000 applicants using our system?

USE BLOCK PRINT to fill in the appropriate information below. Save paper and ink by faxing only this one page to HousingWorks – we will immediately update your information! See fax number below.

☐ **This particular waitlist is closed: Our only open waitlists at present are:**

☐ **This is not the correct application. The correct application is available in this way:**

Your position or title at this housing program: _____

Your signature: _____

HousingWorks Fax: 617-536-8561

*If you advise applicants to use our free search to locate OTHER HOUSING OPTIONS,
you eliminate hundreds of phone calls and reduce frivolous applications.*

www.housingworks.net

DO NOT LEAVE A SINGLE QUESTION UNANSWERED!

- ☐ HEAD OF HOUSEHOLD'S FIRST NAME
- ☐ HEAD OF HOUSEHOLD'S COMPLETE MIDDLE NAME
- ☐ HEAD OF HOUSEHOLD'S LAST NAME (EX: BAEZ GONZALEZ)

☐ SUFFIX _____
- ☐ YOUR MOTHER'S LAST NAME WHEN SHE WAS A CHILD

ANSWER THIS: ☐ Yes ☐ No Does the HoH have a Social Security Number? *If “Yes” you must provide the full SSN!*

- ☐ HEAD OF HOUSEHOLD'S SOCIAL SECURITY NUMBER
- ☐ HEAD OF HOUSEHOLD's DATE OF BIRTH
- ☐ GENDER

- ☐ ETHNICITY
- ☐ RACE: Asian , Black, White, Native American, Pacific Islander, Multi-racial

- ☐ REQUESTED ACCOMMODATIONS Fill in the circle for anything you need:

☐ **Fully Accessible Wheelchair** Unit

☐ **No-Steps unit** (elevator to any floor)

☐ **First-Floor unit only**

☐ **Blind Accessible** Unit

☐ **Deaf Accessible** Unit

☐ Unit for **Environmental Allergies**

☐ Need an **Interpreter**

☐ **Domestic Violence Victim**

☐ **Personal Care Attendant**

- ☐ HoH's CAREER STAGE

☐ Employed☐ Unemployed☐ Retired☐ FT Student☐ PT Student

☐ ANY VETERANS in HH?

☐ Yes☐ No
- ☐ PERMANENT MOBILE RENTAL ASSISTANCE, if any

☐ I do not have mobile rental assistance☐ Mobile Section 8 voucher☐ MRVP☐ AHVP☐ VASH or similar

☐ CRIMINAL RECORD AND SEX OFFENDER

Head of Household:

Any **Felony/Conviction?**

☐ Yes

☐ No

Any **Misdemeanor Conviction?**

☐ Yes

☐ No

Other Members:

Any **Felony Convictions?**

☐ Yes

☐ No

Any **Misdemeanor Conviction?**

☐ Yes

☐ No

Is anyone in HH subject to a **lifetime sex offender registration** in any state?

☐ Yes

☐ No

- ☐ ANY PETS?

☐ Yes

☐ No

Describe: _____

- ☐ HOUSEHOLD SIZE AND COMPOSITION

_____ ← # Adults

_____ ← # Children

_____ ← Total # in Household

☐ ANNUAL INCOME

☐ DOCUMENTED DISABILITY?

☐ Yes

☐ No

- ☐ CURRENT HOUSING STATUS

☐ Homeless☐ Housing Loss in 14 days☐ Homeless under other federal status

☐ Homeless because Fleeing domestic violence☐ At risk of homelessness☐ Stably Housed
- ☐ BEST TELEPHONE NUMBER TO USE

☐ SECOND TELEPHONE
- ☐ EMAIL ADDRESS
- ☐ WHERE YOU LIVE (OR BACKUP MAILING ADDRESS)
- ☐ PREFERRED MAILING ADDRESS
- ☐ # BEDROOMS NEEDED?

☐ SPECIAL CIRCUMSTANCES? (some programs may grant you priority status)
- ☐ Disability☐ Elder☐ Veteran☐ Fleeing Domestic Violence☐ Rent-burdened

Displaced by

☐ Public Action☐ Sanitary Code☐ Natural Forces☐ Other _____

For Office Use Only:

Group:

Preference:

Date Rec'd:

Time Rec'd:

Residential Status

☐ resident ☐ non-resident

FALMOUTH HOUSING AUTHORITY

115 Scranton Avenue
FALMOUTH MASSACHUSETTS 02540-3598
(508) 548-1977 • (508) 540-2956

Disabled Independent
Adult Living (DIAL) Program

Application Number

NAME SOCIAL SECURITY #

MAIL ADDRESS OR P.O. BOX

CITY STATE ZIP

LIVING ADDRESS CITY/STATE ZIP

PHONE NUMBER BIRTH DATE RACE

PERSON OR PERSONS TO RESIDE IN ACCOMMODATION OTHER THAN YOURSELF:

NAME SEX AGE DATE OF BIRTH

SOCIAL SECURITY # RELATION TO APPLICANT

MARITAL STATUS: PLEASE CHECK ONE

Married () Single () Separated () Divorced () Widowed ()

INCOME INFORMATION

PLEASE INDICATE AMOUNT

Social Security

Salary

SSI or SSD

Unemployment Benefits

Public Assistance

Pensions

Veterans Benefits

Alimony

Other

ASSETS: (PLEASE INDICATE AMOUNT)

Do you have a bank account?

Name of Bank:

Savings Acc't No.

Checking Acc't No.

Stocks Bonds Trust

Mutual Funds Annuities

Real Estate

Amount of Principal

Amount of Interest

Savings

Checking

Stocks

ALL OF THE ABOVE MUST BE VERIFIED

PRESENT HOUSING

LANDLORD'S NAME

LANDLORD'S MAILING ADDRESS

CITY STATE ZIP

DATE MOVED IN DO YOU HAVE A LEASE?

Is the head or spouse of this household handicapped or disabled? Yes ☐ No ☐

If yes, please explain the nature and the extent of the handicap _____

Identify any special housing needs required as a result of the handicap _____

Are you being evicted? Yes ☐ No ☐

If yes, explain the circumstances _____

What is your current rent? _____

What utilities do you pay? _____

Do you have a kitchen? Yes ☐ No ☐

Do you have indoor plumbing? Yes ☐ No ☐

Has the city notified you that your house is substandard? Yes ☐ No ☐

Do you own a home or other real estate? Yes ☐ No ☐

Have you sold or given away real property in the past two years? Yes ☐ No ☐

If yes, what is the current market value of the asset or property? _____

=====

HANDICAPPED FAMILIES ONLY:

Do you pay for a care attendant or for any equipment for the handicapped member(s) of the family necessary to permit that person or someone else in the family to work? Yes ☐ No ☐ If yes, describe expenses _____

Do you have Medicare? Yes ☐ No ☐ If yes, what is your premium? _____

Do you have any other kind of medical insurance? Yes ☐ No ☐ If yes, give policy # and agent's name _____

Do you receive assistance through the welfare department? Yes ☐ No ☐

Do you have any outstanding medical bills on which you are paying? Yes ☐ No ☐

Do you expect to have any medical expenses during the next 12 months? Yes ☐ No ☐ If yes, amount of medical expenses _____

=====

WHO TO NOTIFY IN CASE OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE NUMBER: HOME: _____ WORK: _____

PHYSICIAN: _____ ADDRESS: _____

PHONE NUMBER: _____

DO YOU OWN AN AUTOMOBILE? YES () NO ()

DO YOU OWN A PET? YES () NO () IF YES, WHAT KIND? _____

WARNING: Section 1001 of title 18 of the U.S. code makes it a criminal offense to make wilful false statements or misrepresentations to any department or agency of the United States Government as to any matter within its jurisdiction.

Applicant's signature _____ Date _____



FALMOUTH HOUSING AUTHORITY

115 Scranton Ave.
FALMOUTH, MASSACHUSETTS 02540-3598
548-1977 - 540-2956
FAX (508) 457-7573
TDD 1-800-545-1833 Ext. 185

Verification of Income

Dear Agency Representative:

We are required to verify the income of all persons either applying for or currently receiving housing assistance from this office. We ask your cooperation in supplying information indicated below. This information will be held in confidence for use only in determining eligibility or rent payment under our housing programs. Below is a signed authorization for your release of this information to us. Your prompt return of the information will be appreciated.

Sincerely,

Robert H. Murray, Executive Director

I hereby authorize the release to the Falmouth Housing Authority the information indicated below.

Print Tenant Name

Social Security Number

Tenant Signature

Date

TO BE COMPLETED BY AGENCY REPRESENTATIVE

Source of Income

GROSS amount per month

Deductions (if any
PLEASE SPECIFY

AFDC

\$

\$

CHILD SUPPORT

\$

\$

EAEDC

\$

\$

SOCIAL SECURITY

\$

\$

SSI

\$

\$

VA PENSION

\$

\$

PENSION

\$

\$

OTHER

\$

\$

SIGNATURE

TITLE

DATE



Equal Opportunity Housing and Employment





FALMOUTH HOUSING AUTHORITY

115 Scranton Ave.
FALMOUTH, MASSACHUSETTS 02540-3598
548-1977 - 540-2956
FAX (508) 457-7573
TDD 1-800-545-1833 Ext. 185

NOTICE TO APPLICANTS REGARDING ACCESS TO CRIMINAL OFFENDER RECORD INFORMATION

Pursuant to Massachusetts General Laws, Chapter 6, Section 168, Massachusetts agencies administering subsidized housing programs pursuant to 42 U.S.C. 1437(f) and pursuant to 803 CMR 5.00, have been granted access to Criminal Offenders Record Information (CORI) including all pending criminal case data and criminal conviction data for the purpose of evaluating otherwise qualified applicants for subsidized housing under any of the above programs.

Have you ever been charged with a misdemeanor or felony? Yes No

I understand that the Falmouth Housing Authority will obtain any information provided to them by the Criminal History Systems Board of the Commonwealth of Massachusetts. This information may be used for the purpose of determining my eligibility for housing.

I understand that any information pertaining to violent criminal activity or drug-related criminal activity may be grounds for denial of my application.

Name (signature)

Date

Birth Date

Social Security Number

Name (Print) and Current Address



Equal Opportunity Housing and Employment



FALMOUTH HOUSING AUTHORITY

115 Scranton Avenue
FALMOUTH, MASSACHUSETTS 02540
548-1977 - 540-2956

Medical Certification of Handicapped Status

Please sign and give this notice to your physician

Release by Applicant

DATE: _____

SOCIAL SECURITY #

NAME: _____

ADDRESS: _____

I hereby authorize my physician to release any required medical information to:

The Falmouth Housing Authority

APPLICANT SIGNATURE

DATE

The Falmouth Housing Authority is seeking to clarify whether this applicant is disabled per the following State Regulation 760 CMR 5.07 and Sections I and 3 of Chapter 121B, M.G.L. **Certification from a medical doctor is necessary to confirm handicapped status.** This is for the purpose of determining eligibility for our Elderly / Handicapped Program. Your patient's application cannot be processed until we receive verification from you. Thank you for your cooperation.

I confirm the following three (3) statements which are necessary in order to classify the applicant as "handicapped" and as eligible:

- (a) This person has a physical or mental Impairment which is expected to be of long and continued duration, but at least for more than six months:

- (b) This person has an Impairment that substantially impedes the ability to live Independently In conventional housing

- (c) This person has an impairment of such a nature that the ability to live independently could be improved by more suitable housing:



Equal Opportunity Housing and Employment



FALMOUTH HOUSING AUTHORITY

A person with a qualifying physical impairment shall include but not be limited to:

1. A person confined to a wheelchair;
2. A person who, because of use of braces or crutches, or because of the loss of a foot or a leg, or because of an arthritic spastic, pulmonary or cardiac condition, walks with difficulty or insecurity;
3. A person who, due to a brain, spinal or peripheral nerve injury, suffers from faulty coordination or palsy;
4. A person who is blind or whose sight is so impaired that when functioning in a public area he is insecure or exposed to danger;
5. A person whose hearing is so impaired that he can't hear warning signals;
6. One who has a developmental disability which prevents him from living totally independently and would benefit from specialized housing (may include those with cerebral palsy, mental retardation, and epilepsy).

Physician Comments:

PLEASE **PRINT** NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE



Equal Opportunity Housing and Employment





FALMOUTH HOUSING AUTHORITY

115 Scranton Ave.
FALMOUTH, MASSACHUSETTS 02540-3598
548-1977 - 540-2956
FAX (508) 457-7573
TDD 1-800-545-1833 Ext. 185

REQUEST FOR A REASONABLE ACCOMMODATION (FOR FAMILIES WITH A DISABLED HOUSEHOLD MEMBER ONLY)

Name _____ Phone _____

Address _____

1. The following member of my household has a disability: _____

2. Please provide the following change or changes so that the person listed above can live as easily or successfully as other residents or program participants:

3. A change in the following rule or the way you do things. I understand that I may ask for changes in how I meet the terms of the lease, but that everyone must continue to meet the terms of the lease. Please tell us what you need:

4. You may verify the need for this request by contacting:

Name _____ Address _____

Phone _____

I give you permission to contact the above individual for purposes of verifying that a reasonable accommodation is necessary.

Signature _____ Date _____



Equal Opportunity Housing and Employment

