

Application No: \_\_\_\_\_

Date Received: \_\_\_\_\_

**ROBERT EDWARDS BUILDING HOUSING APPLICATION**



Please **Circle** one: *SINGLE APPLICANT* or *COUPLE*

**Check** one for HUD Statistics: Caucasian \_\_\_\_\_ African American \_\_\_\_\_  
American Indian \_\_\_\_\_ Asian \_\_\_\_\_  
Spanish American \_\_\_\_\_ Other \_\_\_\_\_

**RESIDENCE REQUIREMENTS**

1. Applicants must be 62 years of age or older with a physical limitation requiring minimal supportive services.
2. Must be a Montgomery County Resident or proof that you have been a household member of a Montgomery County Resident.

In addition, applicants must:

1. Meet the minimum requirements with respect to Activities of Daily Living as defined under 00-06 Operating Policies and Procedures for Assisted Housing (attached). A medical questionnaire completed by the applicant's physician and based on an examination made within 45 days before the final interview is required.
2. Satisfy Federal and State requirements as to maximum income and assets. Proof of income and assets will be required.

**A. PERSONAL**

Applicant Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

Present Residential County \_\_\_\_\_ How long in Montgomery County? \_\_\_\_\_

Rent or Own? \_\_\_\_\_ Monthly Rent/Mortgage Payment \$ \_\_\_\_\_

If rented, is part of rent subsidized by the Government? Yes \_\_\_ No \_\_\_

How long at current address? \_\_\_\_\_ Landlord's Phone No. \_\_\_\_\_

Name and Address of Landlord \_\_\_\_\_

Why do you want to move from current address? \_\_\_\_\_

Do you live alone? \_\_\_\_\_ If not, with whom? \_\_\_\_\_

How often do you have personal contact with members of your family?

\_\_\_\_\_

## **B. PREVIOUS RESIDENCE**

Last Previous Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How long, from \_\_\_\_\_ To \_\_\_\_\_ Landlord \_\_\_\_\_

Landlord's telephone number \_\_\_\_\_

## **C. MEDICAL**

### **1. APPLICANT**

What Medical Insurance do you have? Blue Cross/Blue Shield; Medicare; Other

\_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Address [complete] \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

How often do you visit your doctor? \_\_\_\_\_

Have you been hospitalized within the past year? Yes \_\_\_ No \_\_\_

Do you receive any special kind of medical treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what and how often? \_\_\_\_\_

Do you require any special in-home therapies, such as oxygen, or dialysis?

Yes\_\_\_No\_\_\_ If "Yes", what and how often \_\_\_\_\_

How would you describe your health? Good\_\_\_\_ Fair\_\_\_\_ Poor \_\_\_\_\_

Describe nature of physical limitations: \_\_\_\_\_

\_\_\_\_\_

Do you need any help in taking your medication? Yes\_\_\_\_ No \_\_\_\_\_

Explain \_\_\_\_\_

Does your health interfere with your ability to maintain your home or apt?

Yes\_\_\_ No\_\_\_ If so, explain \_\_\_\_\_

Do you presently have housekeeping services? Yes\_\_\_ No\_\_\_ If so how often

\_\_\_\_\_

Are you on a special diet? Yes\_\_\_ No\_\_\_ If so, describe: \_\_\_\_\_

\_\_\_\_\_

## **2. SPOUSE MEDICAL**

Name of Doctor:

\_\_\_\_\_

Address (complete)\_\_\_\_\_ Zip \_\_\_\_\_

Telephone No \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

How often do you visit your doctor? \_\_\_\_\_

Have you been hospitalized within the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what for and for how long \_\_\_\_\_

Do you receive any special kind of medical treatment? Yes \_\_\_\_ No \_\_\_\_

If so, what and how often? \_\_\_\_\_

Do you require any special in-home therapies, such as oxygen, or dialysis?

Yes \_\_\_ No \_\_\_ If "Yes", what and how often? \_\_\_\_\_

How would you describe your health? Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

Describe nature of physical limitations: \_\_\_\_\_

\_\_\_\_\_

Do you need any help in taking your medication? Yes \_\_\_\_ No \_\_\_\_

Explain? \_\_\_\_\_

Does your health interfere with your ability to maintain your home or apt?

Yes \_\_\_\_ No \_\_\_\_ If so, explain \_\_\_\_\_

Do you presently have housekeeping services? Yes \_\_\_\_ No \_\_\_\_

If so, how often? \_\_\_\_\_

Are you on a special diet? Yes \_\_\_\_ No \_\_\_\_ If so, describe: \_\_\_\_\_

\_\_\_\_\_

## D. FINANCIAL

### 1. INCOME

	<u>MONTHLY</u>		<u>ANNUALLY</u>	
	<u>Applicant</u>	<u>- Spouse</u>	<u>Applicant</u>	<u>- Spouse</u>
Salary	_____	_____	_____	_____
Social Security	_____	_____	_____	_____
Supplemental	_____	_____	_____	_____
Security Income	_____	_____	_____	_____
Pension	_____	_____	_____	_____
[Source]:	_____	_____	_____	_____
Rental Property	_____	_____	_____	_____
Income:	_____	_____	_____	_____
Deed of Trust	_____	_____	_____	_____
Mortgage Held:	_____	_____	_____	_____
Interest on Savings	_____	_____	_____	_____
Certificates of	_____	_____	_____	_____
Deposit Interest:	_____	_____	_____	_____

Stock Dividends &/or				
Bond Interest:	_____	_____	_____	_____
Other Investments	_____	_____	_____	_____
[e.g. Money Mkt.]	_____	_____	_____	_____
Other Income [e.g. from Children				
or Relatives]	_____	_____	_____	_____
Public Assistance	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____
Total Income	_____	_____	_____	_____

Do you receive Food Stamps? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much per month \_\_\_\_\_

Have you sold or given away real estate property or other assets in the past two years? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what was the market value of the asset? \_\_\_\_\_

## 2. Capital Assets

If real estate is owned, give location, description of property, and its value:

\_\_\_\_\_

Is there a mortgage? \_\_\_\_\_ Who holds it? \_\_\_\_\_

How much real estate tax are you paying on the properties you currently own? \_\_\_\_\_

What stocks and/or bonds do you own?

<u>Name</u>	<u>Number of Shares</u>	<u>Current Value</u>
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other investments do you have?

<u>Name</u>	<u>Description</u>	<u>Current Value</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List certificates of deposit you have

<u>Bank</u>	<u>Certificate Numbers</u>	<u>Account No.#</u>	<u>Current Value</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all checking accounts

<u>Bank</u>	<u>Location</u>	<u>Account No.#</u>	<u>Balance</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all saving accounts

<u>Bank</u>	<u>Location</u>	<u>Account No.#</u>	<u>Balance</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List credit references:

1. \_\_\_\_\_ Account No. \_\_\_\_\_

2. \_\_\_\_\_ Account No. \_\_\_\_\_

### **E. OTHER INFORMATION**

Will you need parking for your car? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give make, model and year of car: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

How did you hear about Homecrest House Assisted Housing? \_\_\_\_\_

\_\_\_\_\_

If you don't get into Homecrest House, what will you do? \_\_\_\_\_

\_\_\_\_\_

How quickly could you move if accepted? \_\_\_\_\_

Have you read the attached minimal requirements with respect to Activities of Daily Living? Yes \_\_\_\_\_ No \_\_\_\_\_

To the best of your knowledge do you feel you meet these requirements?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently on a waiting list for other Assisted Independent Living Housing? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes" what facility \_\_\_\_\_

\_\_\_\_\_

### **F. REFERENCES**

List individuals who have particular knowledge of your circumstances and needs:  
(Must give complete addresses including zip code)

<u>Name</u>	<u>Address</u>	<u>Telephone No.#</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In Case of a medical or other emergency, who should be notified other than your physician?

	<u>Name</u>	<u>Address</u>
1.	_____	_____
2.	_____	_____

	<u>Day Phone</u>	<u>Night Phone</u>	<u>Relationship</u>
1.	_____	_____	_____
2.	_____	_____	_____

List other members of your immediate family, for example, sons and daughters. If no immediate family members are living, list brothers, sisters, and other relatives.

	<u>Name</u>	<u>Address</u>	<u>Telephone No.#</u>	<u>Relationship</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I certify that all information provided herein is true and correct to the best of my knowledge. I understand that if any of the information contained herein is found to be false, the application will be rejected and/or I will be subject to removal.

I will, upon request, furnish substantiation of any information set forth herein and will be available for a personal interview.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Also complete attached forms, enclose a copy of your Social Security card, a copy of your birth certificate, and then mail, or hand deliver this application and all attached forms to:**

**National Capital B'nai B'rith Assisted Housing Corp.  
14514 Homecrest Road, Silver Spring, MD 20906**

**FORM A**

**HEAD**

A Project of  
THE NATIONAL CAPITAL B'NAI B'RITH ASSISTED HOUSING CORP.  
14514 Homecrest Road, Silver Spring, MD 20906

I Authorize the release of all information or history concerning me from my physician or from any medical, financial, or social service agencies and institutions. This authorization is effective for one year following the below applicant's signature date.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

HEAD

INCOME TAX STATEMENT \*

Date: \_\_\_\_\_

This is to certify that I have not filed Federal Income Tax in the past  
**Three** Years.

Signed: \_\_\_\_\_

\*ONLY SIGN IF APPLICABLE

\*If you have filed, please submit with this application a copy of  
Your Federal Income Tax filings for the past two years.

**FORM B**

**SPOUSE**

A Project of  
THE NATIONAL CAPITAL B'NAI B'RITH ASSISTED HOUSING CORP.  
14514 Homecrest Road, Silver Spring, MD 20906

I Authorize the release of all information or history concerning me from my physician or from any medical, financial, or social service agencies and institutions.

This authorization is effective for one year following the below applicant's signature date.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**SPOUSE**

**INCOME TAX STATEMENT \***

Date: \_\_\_\_\_

This is to certify that I have not filed Federal Income Tax in the past **Three** Years.

Signed: \_\_\_\_\_

\*ONLY SIGN IF APPLICABLE

\*If you have filed, please submit with this application a copy of your Federal Income Tax Filings for the past two years.