PRELIMINARY APPLICATION

Federally Subsidized Multi-Family Housing Programs

All information contained herein will be held in strict confidence.
All information will be subject to verification.

FOR OFFICE USE ONLY

LOG#_____

Elderly ____
Handicapped ____
Enriched Housing

Mail Only One (1) Application per Family by Regular Mail.
(Do Not Send By Registered or Certified Mail.)

Mail To: **CLINTON GARDENS**
Management Office
404 West 54th Street
New York, NY 10019

****Clinton Gardens does not discriminate on the basis of disability in admission or access to the building. Auxiliary Aides and services will be made available upon request to individuals with disabilities.***

Each application received will be recorded. Since so many families/elderly need housing, this Development will not be able to accommodate all who are eligible. As families can be reached, they will be called in for an interview.

No Payment or Fee Should Be Given To Anyone In Connection With The Preparation, Filing or Processing of This Application for Subsidized Housing.

Please read the enclosed material carefully. **(THIS APPLICATION IS FOR Enriched Housing Program ONLY, STANDARD WAITING LIST IS CLOSED)**

_____ **Enriched Housing Program**
Complete Preliminary Application (Part A)
and Enriched Housing Questionnaire (Part B)

PART A

SECTION 1 **PERSONAL DATA**

1. Your Name:_____ Sex: ____ Female ___ Male

2. Street:_____ Apt. No.:_____

3. City:_____ State:_____ Zip:_____

4. Telephone No._____ Alternate No._____

5. Date of Birth _____ Social Security No. _____

6. How long have you lived at this address? _____

7. Will someone live with you? _____ Yes _____ No

If yes, what is his/her relationship to you? _____

Please provide the following information about this person:

Name: _____ Social Security No.: _____

Date of Birth: _____ Sex: _____ Female _____ Male

8. Will you require an accessible unit? _____ Yes _____ No

SECTION 2	FINANCIAL

INCOME INFORMATION: Head of Household

Head of Household	Dollar Value	Description
Social Security/SSI	$_____ per _____	
Pension	$_____ per _____	
Employment	$_____ per _____	
Disability	$_____ per _____	
Interest/Dividends	$_____ per _____	
Other	$_____ per _____	

INCOME INFORMATION: Second Person

Second Person	Dollar Value	Description
Social Security/SSI	$_____ per _____	
Pension	$_____ per _____	
Employment	$_____ per _____	
Disability	$_____ per _____	
Interest/Dividends	$_____ per _____	
Other	$_____ per _____	

ASSET INFORMATION: Indicate Type of Account (Checking, Savings, Certificate of Deposit, and which person is the owner)

TYPE	BANK	ACCOUNT #	BALANCE	HEAD/OTHER

Stocks and Bonds (Total Value): $_____

Other Assets: _____ Value ($):_____

Do you now own Real Estate? _____ Yes _____ No If "Yes", what is the value? $_____

Has any family member disposed of any asset for less than fair market value during the past two (2) years? _____ Yes _____ No

If "Yes", explain: _____

SECTION 3 MEDICAL

Medical Expenses:

What are the medical expenses anticipated to be paid by your household in the coming 12 month period?

$_____ (**Do not include** expenses that will be paid for you, or reimbursed by an outside agency such as Medicare)

Handicap Expenses:

This question applies **Only** if a family member is Handicapped or Disabled.
What are the medical expenses anticipated to be paid by your household in the coming 12 month period?

$_____ (**Do not include** expenses that will be paid for you, or reimbursed by an outside agency such as Medicare)

Three personal references (Please note that letters from these references will be requested).
Family/Friends Not Acceptable – (e.g. employers, doctors, social workers, clergyman, etc.)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Have you ever been convicted of any crime? _____ Yes _____ No

Do you currently use illegal drugs or abuse alcohol?_____ Yes _____ No

Are you or the other household member currently subject to a lifetime registration requirement under a state sex offender registration program?
Head of Household: _____ Yes _____ No Other Household Member: _____ Yes _____ No

Please list all states in which you have lived _____
Please list all states in which the other household member has lived _____

Project Based or Tenant Based Subsidy

Do you live in Public Housing, State Housing, or Federal Housing and receive the benefit of a monthly housing assistance payment? Yes _____ No _____

If yes, enter: Name of Project _____

Address of Project _____

Telephone No. of Project Manager _____

The following information is required for statistical purposes so that the Department of HUD may determine the degree to which its programs are utilized. This information must be completed. It will not affect the processing of this application.

Racial Group Identification (used for statistical purposes only). Please check one group which identifies the **Head of Household:**

___ White (Non-Hispanic Origin)

___ Black (Non-Hispanic Origin)

___ Hispanic

___ American Indian or Alaskan Native

___ Asian or Pacific Islander

___ Other:_____

PLEASE DO NOT MAIL MORE THAN ONE APPLICATION PER FAMILY. IF MORE THAN ONE APPLICATION IS RECEIVED, ALL APPLICATIONS SUBMITTED BY THE FAMILY WILL BE *DROPPED TO THE BOTTOM OF THE LIST!*

I declare that I have not submitted more than one application and I am not included in anyone else's application. I declare that the statements contained in this application are true and complete to the best of my knowledge.

WARNING: Willful false statements or misrepresentation are a criminal offense under section 1001 of Title 18 of the U.S. Code.

_____ _____

Signature Date

Program Information:

How did you hear about this Development?: ___ Sign posted on building ___ Newspaper

___ Local organization or church ___ Friend or family ___ Enriched Housing List

___ Fair Housing Counseling Center ___ Other

New York Foundation for Senior Citizens
Enriched Housing Program Summary

WHAT IS IT?
A special program, it offers an enriched group living arrangement in the community as an alternative to institutionalization in nursing homes and domiciliary care facilities for the physically frail elderly over 65 whose independent functioning is no longer possible. These are individuals who need assistance in caring for themselves in order to continue to reside in their own homes. This enriched arrangement provides assistance in meal preparation, shopping, housekeeping and personal care necessary to enable them to continue living within the community.

WHO SPONSORS IT?
New York Foundation for Senior Citizens, Inc. (NYFSC) is a non-profit, non-sectarian social service agency. NYFSC conducts this program under contract with the New York State Department of Health.

WHAT DOES THE PROGRAM OFFER?
Each older person in the program has his or her own studio or one bedroom apartment. Enriched Housing residents benefit from shared group experience but each lives as independently as possible with a variety of home care and social services available as needed.

WHERE ARE THE APARTMENTS? WHAT ARE THEY LIKE?
They are located at Clinton Gardens, 404 W. 54th Street, between 9th and 10th Avenues in Manhattan, a beautiful, elevator building for Section 8 eligible low income persons. Every Enriched Housing apartment has a fully equipped modern kitchen and a fully equipped modern bathroom. A communal dining area and socialization space are available for the residents of the program.

WHAT SERVICES ARE PROVIDED FOR THE RESIDENTS?
New York Foundation for Senior Citizens' homemaker/personal care and social service staff provide:

- Limited personal care.
- Help with laundry and housekeeping.
- Assistance in attending recreational activities.
- One hot cooked meal daily. Seven days a week the residents enjoy this meal together in the congregate dining room. Provisions are made for additional food needs. Residents are involved in menu-planning in consultation with a dietitian.
- Help in obtaining social services and transportation for medical care.
- Staff can be reached around the clock in case of emergency.

WHO IS ELIGIBLE?
To be eligible, applicants must meet certain age, health and income requirements.

Age: Applicants must be 65 years of age or older.

Health: The older person must be functionally impaired but must not require full-time personal care or skilled nursing care. For instance, the older person may need help with shopping or cooking, but should be able to feed him or herself. The older person may need help getting in or out of the tub but should be able to wash him or herself.

Income: Applicants may not have an income of more than $41,800.00 a year from all sources, $47,750.00 a year per couple.

WHAT IS THE COST?
This is a non-profit program. The minimum fee for the Enriched Housing program, including rent, food, utilities and services is $1,309.00 a month. A special Enriched Housing program SSI supplement up to $1,535.00 per month is available for persons whose income falls below the cost of the program's services and who are otherwise financially eligible. Fees for persons with monthly income above $1,555.00 will be determined on a sliding scale.

HOW DOES ONE APPLY?
To apply fill out Part A & Part B of application.

PART B

ENRICHED HOUSING QUESTIONNAIRE

PLEASE NOTE: Apply for either the Enriched Housing, which provides support services, or Standard Housing Program. To apply for Enriched Housing; complete information on this sheet, Part B, as well as the Preliminary Application, Part A.

Please read enclosed information on the Enriched Housing Program before filling out this application. To apply for the Enriched Housing Program, please answer all the questions listed below:

SECTION 1 — PERSONAL DATA

1. Your Name:_____ Social Security No:_____

2. Street:_____ Apt. No.:_____

City:_____ State:_____ Zip:_____

4. How long have you lived at this address?_____ Day Tel. No. _____

5. Date of Birth:_____ Sex: _____ Female _____ Male

6. Emergency Contacts:

_____

Name Address Phone

_____

Name Address Phone

SECTION 2 — PRESENT HOUSING

Present Housing Type:

___ Apartment Building

___ Hotel

___ Adult Home

___ Others: _____

Do you receive Medicare: ____ Yes ___ No

If "Yes" your Medicare number:_____

Do you receive Medicaid: ____ Yes ____ No

If "Yes" your Medicaid number:_____

SECTION 3 FUNCTIONAL ABILITY

Describe your ability to function in the following areas:

A. Personal activities of daily living:

1. Walking

___ Independently, without assistance device
___ With difficulty, with or without assistance device
___ With continuous physical support (e.g. cane or walker)
___ Require wheelchair
If an assistance device is used, indicate type:_____

2. Use of Wheelchair

___ Independently, with or without powered chair
___ Require assistance in difficult maneuvering
___ Require total assistance

3. Bathing:

___ No assistance
___ Need assistance

4. Dressing:

___ Dress self
___ Need assistance
___ Have to be dressed

5. Medications:

___ No assistance
___ Need assistance

6. Grooming:

___ No assistance
___ Need minor assistance (e.g. help with washing hair, trimming toenails)
___ Need total assistance

SECTION 3	FUNCTIONAL ABILITY (CONTINUED)

7. Preparing Meals:

___ No assistance
___ Need assistance

8. Shopping:

___ No assistance
___ Need assistance

SECTION 4	SENSORY ABILITY

Sight

___ Good (with or without correction)
___ Vision adequate – unable to read/see details
___ Vision limited
___ Blind

Hearing

___ Good
___ Hearing slightly impaired
___ Limited hearing (e.g. must be spoken to loudly)
___ Virtually/completely deaf

SECTION 5	DAILY FUNCTIONING

Domestic Activities of Daily Functioning:

Do you currently receive housekeeping, home assistance or assistance or any other housekeeping or personal care services? ____ Yes ___ No

If "Yes", specify type or types of services your receive:

_____

_____

_____

How often do you receive these services?

Name of Agency:_____

1. House Cleaning:

___ Need no assistance
___ Need some assistance
___ Need total assistance

2. Laundry:

___ Need no assistance
___ Need some assistance
___ Need total assistance

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ Check this box if you choose not to provide the contact information.

Signature of Applicant **Date**