

**PRELIMINARY APPLICATION**

**FOR OFFICE USE ONLY**

**Federally Subsidized Multi-Family Housing Programs**



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

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: RIVER VIEW GARDENS**  
Management Office  
4-12 49<sup>th</sup> Avenue  
Long Island City, NY 11101

**\*\*River View 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

**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)

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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

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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)

\_\_\_ American Indian or Alaskan Native

\_\_\_ Black (Non-Hispanic Origin)

\_\_\_ Asian or Pacific Islander

\_\_\_ Hispanic

\_\_\_ 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 River View Gardens, 4-12 49<sup>th</sup> Avenue, in Long Island City, a beautiful, elevator building for Section 202 PRAC 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 \$54,350.00 a year from all sources, \$62,150.00 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 \$1,387.00 a month. A special Enriched Housing program SSI supplement up to \$1,637.00 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 \$1,657.00 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
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Name	Address	Phone
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**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: \_\_\_\_\_

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 you receive:

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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



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.

<b>Applicant Name:</b>	
<b>Mailing Address:</b>	
<b>Telephone No:</b>	<b>Cell Phone No:</b>
<b>Name of Additional Contact Person or Organization:</b>	
<b>Address:</b>	
<b>Telephone No:</b>	<b>Cell Phone No:</b>
<b>E-Mail Address (if applicable):</b>	
<b>Relationship to Applicant:</b>	
<b>Reason for Contact:</b> (Check all that apply)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Assist with Recertification Process
<input type="checkbox"/> Unable to contact you	<input type="checkbox"/> Change in lease terms
<input type="checkbox"/> Termination of rental assistance	<input type="checkbox"/> Change in house rules
<input type="checkbox"/> Eviction from unit	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Late payment of rent	
<b>Commitment of Housing Authority or Owner:</b> 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.	
<b>Confidentiality Statement:</b> The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
<b>Legal Notification:</b> 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.

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**Signature of Applicant**

**Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

**Privacy Statement:** Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.