

Montclair Shared Housing Association
The Montclair Inn
27 Hillside Avenue
Montclair, NJ 07042

RESIDENCY APPLICATION

GENERAL INFORMATION

DATE:

APPLICANT NAME:

SOCIAL SECURITY #:

PRESENT ADDRESS:

TELEPHONE #:

EMAIL:

SEX: M F AGE: DATE OF BIRTH:

MARITAL STATUS: Single MARRIED SEPERATED DIVORCEE WIDOWED

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED

OCCUPATION (former if retired):

EMPLOYER (former if retired):

HOUSING:

Describe your current housing (house or apt., own or rent, live alone or share, with relatives, assisted living, etc.):

How long have you lived at current address?:

If renting, current monthly rent (\$/month):

Landlord name, address and phone #:

Previous residences (in last 10 years):

Address	Rent: \$/Month	Name and Phone # of Landlord
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever been evicted from an apartment, or asked to leave a residence or facility? Yes No

If Yes, please explain:

INCOME

Include all sources. Use TABLE to calculate.

TABLE: Anticipated Annual Income

Wages/Salaries:

Social Security Benefits:

Pensions/Other Benefits:

Section 8:

Public Assistance:

Workers comp.:

Other Income (relatives, friends):

Asset Income (income from savings accounts, CODs, IRA's, real estate, stocks, bonds, money market accts., etc.)

Total Annual Income:

If unsure, please explain and circle an approximate annual income:

\$15,000-\$25,000 \$25,000-\$32,000 \$32,000-\$52,000 \$52,000-\$100,000 over \$100,000

Will get assistance with rent from:

MEDICAL: Medical information is required under state licensing regulations, but kept confidential. The Inn is an equal opportunity housing provider and makes admissions decision according to fair housing laws and state licensing requirements.

What is your general physical and mental health?

Excellent Very Good Good Fair

Please describe:

Do you need to be reminded to take medication? Yes No

Have you ever stopped taking prescribed medication? Yes No

If yes, what were the consequences?

If yes, did it result in your being hospitalized?

Are you in need of regular assistance for your daily personal care needs such as bathing, dressing, taking medication, doing laundry, etc.? Yes No

If Yes, please explain who helps you and for what reasons:

Are you able to manage stairs with or without an assistive device? Yes No

Does your physical or mental health interfere with your day to day activities? Yes No

If Yes, please explain:

Please list any health conditions you have and medication prescribed:

Conditions	Medication	When Taken
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Over the past ten years, have you been admitted to the hospital? Yes No

If Yes, please explain:

Hospital	Reason	Date and length of hospitalization	Follow-up Care
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Physician:

Name: Address:

Phone: Email:

Other physicians or medical providers (psychiatrist, physical therapist, etc.).

Name: Specialty:

Address: Phone:

Name: Specialty:

Address: Phone:

Do you smoke? Yes No Number of packs: per day per week

Have you appointed a **POWER of ATTORNEY** or has a **GUARDIAN** been assigned to you?

Yes No

If Yes, please provide:

Name: Phone:
Address: Email:

Description of POA or guardianship: Legal/financial Medical Both Other

Is someone other than you financially responsible for paying your rent? Yes No

If Yes, please provide:

Name: Phone:
Address: Email:

Relationship to you and arrangement to make payments:

Do you have an Advanced Directive and/or Living Will? Yes No

If Yes, please provide a copy.

NON-FAMILY REFERENCE:

Name: Address:
Phone:

Please send all the below documents listed to MontclairInn@gmail.com to be fully considered.

- Birth Certificate
- Proof of Ability to Pay
- Medication Certification
- Personal References
- Landlord References
- Advanced Directive/Living Will
- Power of Attorney