Congregate Housing Guidelines

Congregate Housing is a shared living environment that combines affordable housing with support services. It is for those who find it difficult to live alone and enjoy the security of living with others. Congregate Housing promotes socialization and independence and tries to prevent unnecessary nursing home placement. Each resident has a private apartment with a half bathroom. The kitchen, shower facilities, dining areas and living rooms are all shared space. Each applicant must meet the age and financial requirements established by the Department of Housing Communities and Development. All applicants must pass a CORI and landlord references.

- Each resident is required to be capable of independent living:
  - Does not require 24 hour supervision
  - Does not require maximal assistance to carry out activities of daily living
  - Is able to perform transfers without assistance
  - Is able to manage finances or have arrangements made to assist
  - Is oriented to time, place and person
- Each resident must display a need for the support provided by congregate living:
  - May require assistance with areas of daily living
  - Would benefit from social interaction on a daily basis
  - Will participate in scheduled group activities/meals
- Each resident is expected to reside in the congregate for a minimum of one year: (barring infrequent, unexpected and acute episodes of illness)
  - Must be medically stable
  - Must be medically compliant and able to follow medical plan established by physician or MAT RN
  - Does not exhibit behavior harmful to himself/herself or others
  - Behaviors must not have a negative impact on other residents and the function of the unit
- It is imperative that each applicant have an understanding of the concept of congregate housing and the expectations as a resident such as:
  - Respecting other residents, their belongings and personal space
  - Understanding the concept of shared living and the responsibilities that go along with individual participation
- Each applicant is required to have seen his/her physician within six months prior to applying.
- Each applicant being discharged from a skilled nursing facility is required to have an on-site OT evaluation prior to tenancy approval.
- Each tenant agrees to have the Congregate Coordinator assist with arranging appropriate living arrangements when congregate housing is no longer a suitable option.
- Each applicant's eligibility is determined by the MAT (Multi-disciplinary Assessment Team). This team is comprised of the Congregate Coordinator, an RN from the local VNA and a representative from the local Housing Authority.

Please submit the following along with the completed application.

1. Birth Certificate and Social Security card
2. Picture identification and/or passport
3. Verification of all income such as your gross Social Security Benefit Statement, SSI, Pension, Wages, etc. 6 most recent pay stubs
4. Verification of all bank accounts, including 401k, Stocks, Bonds, etc.
6. Checking and Savings Account statements showing at least a 30 day period
7. Verification of Health Insurance premium and verification of payment.
8. Verification of all out of pocket paid medical expenses for the last 12 months including prescriptions.
9. Verification of any Real Estate owned by applicant(s).
10. Address for the last 5 years including the name and current address of the landlord.

dhcd Massachusetts

This box is for Office Use Only	
Date of Receipt:	
Time of Receipt:	
Control Number:	
Barrier free:	
First Floor:	
Elderly Handicapped:	
Race and/or Ethnicity:	
Priority /Preference Category:	
Language:	

Incomplete applications will not be processed. Please complete all information requested on the application. If a question is not applicable, please write N/A. Make sure you sign the last page. **If you need additional space to provide an answer, please attach an additional sheet(s). Once completed please mail or hand carry to local housing authorities at which you want to apply. Please check the list of local housing authorities for availability of family or elderly/non-elderly handicapped housing.**

1. Name of Applicant: _____

Current Residence Address: _____ Apt No: _____

City / Town: _____ State _____ Zip: _____

Home Telephone: _____ Cell Phone _____

Best # to Reach Applicant _____ Work Phone _____

Mailing Address: _____ Apt No: _____

City / Town: _____ State: _____ Zip: _____

2. Type of Public Housing You are Applying For

☐ Congregate Elderly/Handicapped

Note: To be eligible for elderly/handicapped housing you must be at least 60 years old or a person with a handicap. If you have a handicap, the handicap must be other than a history of alcohol/drug abuse. If you have a handicap, you must provide certification by a doctor clearly stating that you have a handicap and it is expected to be of long and indefinite in duration lasting at least six months. In addition, the LHA will need to determine that certain special architectural features OR low rent housing is not available in the private market AND that the applicant is faced with living in an institution or decadent substandard housing OR the applicant is paying excessive rents.

3. If you want to apply for emergency Housing you must select one of the categories below:

Note: To be eligible for Emergency applicant status you must be "homeless," which is defined by state regulations as: an applicant who is without a place to live or who is in a living situation in which there is a significant, immediate and direct threat of life of safety that would be alleviated by placement in an appropriate unit, who has not caused or substantially contributed to the situation, who has made reasonable efforts to prevent of avoid the situation and to locate alternative housing, and who is displaced from is/her primary residence for one of the following reasons. Please check the reason that applied to your situation.

- ☐ Displaced by Natural Forces (i.e. Fire, Flood, Earthquake)
- ☐ Displaced by Public Action (i.e. Urban renewal, eminent domain)
- ☐ Displaced by Public Action (i.e. Condemnation of home, code violations)
- ☐ Displaced by No-fault of housing, Severe Medical emergency and/or Victim of Abuse (domestic violence) where the housing situation significantly contributes to or is direct threat to the life and safety of the applicant.

If you have selected one of the above emergency categories in this section, you must complete an EMERGENCY APPLICATION in addition to this Standard Application. All emergency applications must be accompanied by third party written documentation.

©2004 Commonwealth of Massachusetts

4. **Local Preference:** In addition to receiving local preference for the City or Town where you principally reside, you may receive local preference based on where you are employed.

Please answer the following:

- Provide the name of the City/Town in which you are employed: _____
- Provide the dates of employment: From: _____ To: _____

Home Telephone _____ Work Telephone _____

5. **Veteran Preference:** You may apply for Veteran Preference if you are a Veteran, the spouse, surviving spouse, dependent parent or child or divorced spouse with a dependent child of a Veteran.

If you wish to apply for Veteran Preference, list the dates of U.S. military service. Include service dates for service in the U.S. Army, Marine Corps, Coast Guard, Air Force or National Guard.
Service Date: From: _____ To: _____

A Copy of the Veteran's Department of Defense Form DD214 must be submitted with this application.

6. Do you have any special needs due to a disability or need a reasonable accommodation such as a first floor unit for medical reasons? ☐ yes ☐ no

Please Specify: _____

_____

_____

_____

7. Do you need a wheelchair accessible apartment? ☐ yes ☐ no

8. Number of Bedrooms needed: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Note: Most elderly / handicapped housing developments only have 1 bedroom units.

9. Are you currently living in a non-permanent transitional housing which is subsidized under the Massachusetts Alternative Housing Voucher Program? ☐ yes ☐ no

©2004 Commonwealth of Massachusetts
Department of Housing & Community Development

10. Does anyone in your household own a car? ☐ yes ☐ no

Make of car: Year: _____ Reg. Number: _____

Make of car: Year: _____ Reg. Number: _____

11. Members of household to live in unit, including Head of Household:

First & Last Name	Relationship To Head of Household	Racial Desig-nation*	Ethnic Desig-nation**	Social Security Number***	Sex	Date of Birth	Occupation • Employed • At Home • Handicapped • Student
	Head						

*Racial Designation: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Other (specify).

**Ethnic Designation: Hispanic/Latino or Not Hispanic/Latino

Responding to these questions is optional. Your status with respect to tenant selection procedures may be affected by this information. "Minority" does not include "White" unless there is also a designation of another race or "Hispanic/Latino".

***This information will be used to verify income, assets, and criminal record information.

12. Is a change in the household composition expected? ☐ yes ☐ no

If yes, what type? _____

When? _____

©2004 Commonwealth of Massachusetts
Department of Housing & Community Development

13. **Income Before Deductions:** Estimate the Gross Income anticipated for ALL household members from all sources for the next 12 month. Specify all sources.

Household Member Name		Name & Address of Employer or Source of Income	Gross Income for Next 12 Months
	Salaries, Wages, including Overtime / Tips		$
	Salaries, Wages, including Overtime / Tips		$
	Net Income from Business or Profession		$
	Trust Income, Interest & Dividends		$
	Unemployment or Disability Compensation		$
	Pensions & Annuities		$
	Regular Social Security Benefits and / or SSI		$
	VA Disability Income		$
	TAFDC or Public Assistance		$
	Regular Alimony Support Payments		$
	Other Income		$
		Total Gross Income:	$

©2004 Commonwealth of Massachusetts
Department of Housing & Community Development

14. **Expenses:**

Un-reimbursed Medical Expenses:	$
Alimony of Child Support Payments:	$
Health Insurance:	$
Other (i.e. expense for care of sick children, or sick incapacitated person if necessary for employment)	$

15. **Assets:** Do you own any real estate? ☐ yes ☐ no

If yes, please provide the address: _____

List below the assets of everyone to live in the unit. Include **all** bank accounts, stocks and bonds, trusts, real estate, etc. **DO NOT** include clothing, furniture or cars. Use additional paper if necessary.

Household Member	Asset Type	Asset Value or Current Balance	Name of Financial Institution	Account No.
		$		
		$		
		$		
		$		
		$		
		$		

16. Have you sold, transferred or given away any real property or assets in the last three (3) years? ☐ yes ☐ no

If yes: Date of sale / transfer: Month _____ Day _____ Year _____
Amount of the sale / transfer: _____
Value of the sale / transfer: _____

17. **References:** List two references. These should not be relatives or household members.

(1) Name _____ Telephone No. _____

Address: _____ City _____ State _____ Zip _____

(2) Name _____ Telephone No. _____

Address: _____ City _____ State _____ Zip _____

18. **List Addresses for each Adult Household Member** for the Last Five Years in Reverse Order. Please list primary lease holder (head of household) if someone other than yourself. (Use additional sheet if necessary)

(1) Name of Primary Leaseholder: _____

Address: _____ Apt # _____ Date From: _____ To: _____

City _____ State _____ Zip _____

Landlord Name _____ Telephone No. _____

Landlord Address: _____ City _____ State _____ Zip _____

Did this landlord bring any court action against the leaseholder or you? (check one) ☐ yes ☐ no

Did this landlord return your security deposit? (check one) ☐ yes ☐ no ☐ n/a

(2) Name of Primary Leaseholder: _____

Address: _____ Apt # _____ Date From: _____ To: _____

City _____ State _____ Zip _____

Landlord Name _____ Telephone No. _____

Landlord Address: _____ City _____ State _____ Zip _____

Did this landlord bring any court action against the leaseholder or you? (check one) ☐ yes ☐ no

Did this landlord return your security deposit? (check one) ☐ yes ☐ no ☐ n/a

(3) Name of Primary Leaseholder: _____

Address: _____ Apt # _____ Date From: _____ To: _____

City _____ State _____ Zip _____

Landlord Name _____ Telephone No. _____

Landlord Address: _____ City _____ State _____ Zip _____

Did this landlord bring any court action against the leaseholder or you? (check one) ☐ yes ☐ no

Did this landlord return your security deposit? (check one) ☐ yes ☐ no ☐ n/a

©2004 Commonwealth of Massachusetts
Department of Housing & Community Development

19. Have you, or any member of your household ever received housing assistance from this or any other housing agency? (check one) ☐ yes ☐ no

If yes, Name of Head of Household at that time: _____

Relation to Applicant: _____

Name of Housing Agency: _____

Date Moved Out: _____

Reason Moved Out: _____

When you moved out, were you in compliance with the lease and other program requirements? (check one) ☐ yes ☐ no

If No, Please Explain: _____

20. Are you a Board Member, employee, or a member of the immediate family of an employee of a board member of this housing Authority? ☐ yes ☐ no If so, this will not necessarily disqualify your application.

If Yes, Please Explain: _____

21. Do you have any pets? ☐ yes ☐ no If so, how many? _____

Please describe: _____

22: Emergency Reference: Name of a relative or friend NOT planning to live with you. We will contact this person if we are not able to reach you in the case of an emergency.

Name: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Telephone: _____ Business Phone: _____ Cell: _____

Email: _____

©2004 Commonwealth of Massachusetts

23. **Criminal Record:** Have you or any member of your household who will live in the unit ever been convicted of a felony? ☐ yes ☐ no

If Yes, Please Explain: _____

_____

_____

_____

24. Do you or any member of your household who will live in the unit have any criminal matters pending?

☐ yes ☐ no

If Yes, Please Explain: _____

_____

_____

_____

APPLICANT'S CERTIFICATION:

I understand that this application is not an offer of housing. I understand that a Housing Authority will make no more than one offer of an appropriate public housing unit. If I do not accept that offer, my application will be removed from the waiting list; and, if I reapply, my application will not receive any priority or preference that was granted on the prior application for a three (3) year period.

Based on this application, I understand I should not make plans to move or end my present tenancy until I have received a written **Unit Offer** from a Housing Authority. I understand that it is my responsibility to inform the Housing Authority in writing of any change of addresses, income, or household composition. I authorize the Housing Authority to make inquiries to verify the information I have provided in this application. I certify that the information I have given in this application is true and correct. I understand that any false statement or misrepresentation may result in the denial of my application. **I understand that the Housing Authority will request Criminal Offender Record Information from the Criminal History Systems Board and perform credit checks and internet searches for all adult members of the household.**

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY; I understand that a photocopy of this application and a photocopy of this signature as valid as the original.

Applicant's Signature: _____ Date: _____

Reviewer's Signature: _____ Date: _____

©2004 Commonwealth of Massachusetts
Department of Housing & Community Development

AYER HOUSING AUTHORITY

18 Pond Street, Ayer, Massachusetts, 01432

Tenant Permission to Release Information

What is the purpose of this form?

- This form gives a State-Aided Housing Agency permission to ask you for certain information to verify the information you provide as part of your tenancy in state-aided public housing or with a state rental housing voucher.

  A State-Aided Housing Agency is a local housing authority or a regional administering agency. State rental housing vouchers include the Massachusetts Rental Housing Voucher Program (MRVP) and the Alternative Housing Voucher Program (AHVP).

- This form gives a State-Aided Housing Agency permission to use and share certain information with the Massachusetts Department of Housing and Community Development (DHCD) to help evaluate housing programs

- This form gives permission to State-Aided Housing Agencies and/or DHCD to share some of your personal information.

Your personal information will only be shared as outlined in this form and as required or allowed by law. Please read carefully before signing this form.

What Personal Information Will State-Aided Housing Agencies and/or DHCD Share?

Shared information may include, but is not limited to:

- biographic information (e.g., name, date of birth);
- demographic information (e.g., address, race, ethnicity, language); and
- income, employment, and other information related to your application for initial eligibility/qualification for, or participation in state-aided Public Housing, MRVP, or AHVP.

What Personal Information Will Not Be Shared?

This form will not be used to share personally identifiable information related to any of the following subjects. If a State-Aided Housing Agency and/or DHCD requires any personally identifiable information related to the following subjects, they will ask for separate written permission for your:

- Medical Information;
- Criminal Information;

- Verification of a Disability;
- Information related to any priority or preference claims, including homelessness and domestic violence; and
- Reasonable Accommodation Information, including that a reasonable accommodation was requested, granted, or denied and/or any medical information submitted as part of a request for reasonable accommodation.

How will your personal information be kept secure?

The personal information you provide through this release will be securely maintained in accordance with applicable law and regulation, including but not limited to M.G.L. c. 66A, Fair Information Practices Act and 760 CMR 8.00, Privacy and Confidentiality.

Can I have access to my personal information and challenge it if it is not accurate or relevant?

Yes. Under 760 CMR 8.05(1), you, or your authorized representative, may file an objection with the State-Aided Housing Agency or DHCD objecting to the accuracy, completeness, pertinence, timeliness, relevance, use or dissemination of your personal data or the denial of access to your personal data.

What happens if I do not sign this Release Form?

Failure to sign this form may result in the denial of assistance, suspension or termination of housing assistance, or repayment of assistance

Will I be notified if information obtained because of this release form results in an action being taken against me?

Yes. You will be notified in writing of actions taken against me because of information gained from verification processes, provided an opportunity to contest the actions, and given information on how to do so.

How long does this Release Form last?

The release is effective from the date of signature until your next scheduled rent determination or certification.

Permission to Verify the Information I Have Provided

- I give permission for all individuals, companies, agencies, offices of the state and federal governments, and their designated contractors, subcontractors, and agents to release any information about me and my household members to State-Aided Housing Agencies and/or DHCD to verify the information I provided in my application.

- I also give permission for State-Aided Housing Agencies and/or DHCD to obtain information (by any means, including oral, written, electronic, facsimile or telephonic) about me and my household members to verify the information I provided in my application to determine eligibility and qualification for the housing programs.

Permission to Share My Information

I give permission for State-Aided Housing Agencies and/or DHCD:

- To use my personal information to inform research, analysis and program evaluation by DHCD, other state agencies, or external partners on DHCD programs or other initiatives that will help DHCD improve state-aided housing assistance programs;
- To use my personal information to make referrals to other state-funded initiatives and benefit programs for eligibility determination, recruitment, and outreach purposes (I do not have to participate in these programs); and
- To comply with state reporting and record keeping requirements.

I agree to cooperate in requests to provide information to the State-Aided Housing Agencies and/or DHCD and I understand if I do not, it may result in me being disqualified or ineligible for state public housing, AHVP, and/or MRVP.

I have read or been read and understand this form. A photocopy or digital copy of this release is as valid as the original.

_____

Head of Household Printed Name

_____

Head of Household Signature
*If typed, my typed name represents my signature.

_____

Date

_____

Other Adult Household Member

_____

Other Adult Household Member Signature

_____

Date

Other Adult Household Member

Other Adult Household Member Signature

Date

Other Adult Household Member

Other Adult Household Member Signature

Date

Other Adult Household Member

Other Adult Household Member Signature

Date

The English version of this Tenant Permission to Release of Information is the official version and must be signed.

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____

Address:_____

I, the above named individual, have authorized the Ayer Housing Authority to verify the accuracy of the information, which I have provided to the Housing Authority from the following sources (specify):

Banks and Other Financial Institutions, Courts, Law Enforcements, Criminal History Systems Boards, Agencies, Credit Bureaus, Employers, Past and Present Landlords, Providers of: Alimony, Child Care, Child Support, Handicapped Assistance, Medical Care, Pensions/Annuities, School and Colleges, U.S. Social Security Administration, U.S. Department of Veteran Affairs, Utility Companies, Welfare Agencies and Enterprise Income Verification System.

I hereby give you my permission to release this information to the Ayer Housing Authority subject to the condition that it be kept confidential. I would appreciate your prompt attention in supplying the information requested on the attached page to the Ayer Housing Authority within five (5) days of receipt of this request.

I understand that a photocopy of this authorization is as valid as the original.

Thank you for your cooperation in this matter.

_____ Date signed:_____

(signature)

THIS AUTHORIZATION IS VALID FOR A PERIOD OF ONE YEAR FROM THE DATE NOTED ABOVE.

FAIR INFORMATION PRACTICES ACT STATEMENT OF RIGHTS

The Ayer Housing Authority collects information about applicants and tenants for its housing programs as required by law in order to determine eligibility, amount of rent, and correct apartment size. The information collected is used to manage the housing programs, to protect the public's financial interest and to verify the accuracy of information submitted. When permitted by law, it may be released to government agencies, other housing authorities, and to civil or criminal investigators or prosecutors. Otherwise, the information will be kept confidential and used only by housing authority staff in the course of their duties.

The Fair Information Practices Act established requirements governing housing authorities' use and disclosure of the information it collects. Applicants and tenants may give or withhold their permission when requested by a housing authority to provide information, however, failure to permit the housing authority to obtain the required information may result in delay, ineligibility for programs, or termination of tenancy or housing subsidy. The provision of false or incomplete information is a criminal offense punishable by fines and/or imprisonment.

As an applicant or tenant, you have the following rights in regard to the information collected about you:

1. No information may be used for any purpose other than those described above without your consent.
2. No information may be disclosed to any person other than those described above without your consent.
3. You or your authorized representative have a right to inspect and copy any information collected about you.
4. You may ask questions and receive answers from the housing authority about how it will collect and use your information.
5. You may object to the collection, maintenance, dissemination, use, accuracy, completeness or type of information the housing authority holds about you. If you object, it will investigate your objection, and either correct the problem or make your objection part of the file. If you are dissatisfied, you may file a grievance under the housing authority's grievance procedure.

I have read and understood this Fair Information Practices Act Statement of Rights and have received a copy for future reference.

Date:_____ _____

Applicant's signature

PUBLIC HOUSING
INCOME/ASSET VERIFICATION

TO WHOM IT MAY CONCERN:
I HEREBY AUTHORIZE AYER HOUSING AUTHORITY TO VERIFY MY INCOME, ASSETS AND OTHER BENEFITS THAT I AM ELIGIBLE FOR OR HAVE RECEIVED IN THE PAST **including utilizing the Enterprise Income Verification System (EIV) to verify wage income, unemployment income, and social security benefit information. (federal tenants only)**

_____ _____ _____
Signature DATE SSN #

THIS FORM WILL BE SENT TO THE FOLLOWING: (check all that apply)

_____SOCIAL SECURITY _____EMPLOYER_____
_____BANK _____ _____ PENSION_____
_____OTHER_____

TO WHOM IT MAY CONCERN:
THE ABOVE NAMED PARTY HAS AUTHORIZED AYER HOUSING AUTHORITY TO VERIFY HIS/HER INCOME/ASSETS. PLEASE COMPLETE AND RETURN THIS FORM IN THE ENCLOSED SELF-ADDRESSED STAMPED ENVELOPE TO AYER HOUSING AUTHORITY, 18 POND STREET, AYER, MA 01432. THANK YOU FOR YOUR COOPERATION.

EMPLOYMENT: Please list last 6 payments of employment earnings, if applicable:
$_____ week ending _____ $_____ week ending _____
$_____ week ending _____ $_____ week ending _____
$_____ week ending _____ $_____ week ending _____

AVERAGE HRS PER WEEK: _____ HEALTH/DENTAL INS.$_____ WEEKLY
DATE OF INITIAL HIRE_____ DATE OF TERMINATION:_____

BENEFITS FROM: PUBLIC ASSISTANCE $_____ PER MONTH
SSA, SSI, PENSION $_____ PER MONTH
UNEMPLOYMENT $_____ PER MONTH

OTHER INCOME: (CHILD SUPPORT, FOSTER CARE PAYMENTS, ETC.)
$_____ PER WEEK MONTH YEAR

BANK ACCOUNTS, ASSETS, ETC.: (Please list additional accounts on back side)

CURRENT BALANCE $_____ INTEREST RATE _____

_____ _____
COMPLETED BY: SIGNATURE DATE

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL.: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

This form is not to be faxed. Please return form to organization.

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for housing purposes.

The Ayer Housing Authority (Organization) is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening applicants for the rental or lease of housing. As an applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to The Ayer Housing Authority (Organization) to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing The Ayer Housing Authority (Organization) with written notice of my intent to withdraw consent to a CORI check.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature of CORI Subject *Date*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/DCJIS

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting. The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last SIX digits of Social Security Number: ___ ___ -- ___ ___ ___ ___ ☐ No Social Security Number

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____

Print Name of Verifying Employee

_____ _____

Signature of Verifying Employee *Date*