

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

RESIDENCY APPLICATION

GENERAL INFORMATION

DATE: _____

APPLICANT'S NAME: _____ SOCIAL SECURITY# _____

PRESENT ADDRESS: _____

TELEPHONE #: _____ EMAIL: _____

SEX: M__ F__ AGE: _____ DATE OF BIRTH ____/____/____

MARITAL STATUS: SINGLE__ MARRIED__ SEPERATED__ DIVORCED__ 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) (Use back of sheet if necessary):

<u>Address</u>	<u>Rent:\$/Mo.</u>	<u>Name and phone number of Landlord</u>
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Have you ever been evicted from an apartment, or asked to leave a residence or facility? _____

If Yes, please explain: _____

INCOME:

Annual 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, investments, CODs, IRA's real estate, stocks, bonds, money market accts., etc.)
Total Annual Income :

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

\$15-25,000 \$25-32,000 \$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 decisions according to fair housing laws and state licensing requirements.

What is your general physical and mental health?

Excellent___ Very Good___ Good___ Fair_____

Please describe:_____

Please list any health conditions you have and medication prescribed:

<u>Conditions</u>	<u>Medication</u>	<u>When Taken</u>

Do you need to be reminded to take medication? Yes_____ No_____

Have you ever stopped taking prescribed medication?_____ 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: _____

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

Primary Physician:

Name _____ Address _____

Phone _____ email: _____

Other physicians or medical providers (psychiatrist, physical therapist, etc.). Please use back of sheet if necessary:

Name: _____ specialty _____

Address _____ Phone _____

Do you smoke? Yes___ No___ Number of packs _____ per day _____ per week _____

PERSONAL:

Why do you want to live at the Montclair Inn?

How would you describe your ability to get along with others?

Special hobbies/interests: _____

Is there any other information about yourself that you think would be helpful to us?

Do you own a car? Yes___ No___ Would you need parking? Yes___ No___

If accepted for residency at the Inn, when would you like to move in? _____

Have you ever been convicted a crime? Yes___ No___ If yes, please explain _____

CONTACT PERSONS: The Inn requires you to have at least one person (child, next of kin, close friend or relative, etc.) who would be willing to assist you case of illness, emergency, or other change of status.

1. Name: _____ Phone _____
Address _____ email _____
Relationship to you: _____
2. Name: _____ Phone _____
Address _____ email _____
Relationship to you: _____

CHILDREN OR OTHER RELATIVES (not listed above):

1. Name: _____ Phone _____
Address _____ email _____
Relationship to you: _____
2. Name: _____ Phone _____
Address _____ email _____
Relationship to you: _____
3. Name: _____ Phone _____
Address _____ email _____
Relationship to you: _____

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 _____

BIRTH CERT.

PROOF OF ABILITY TO PAY

MEDICAL CERTIFICATION

PERSONAL REFERENCES

LANDLORD REFERENCES

ADVANCED DIRECTIVE/LIVING WILL

POWER OF ATTORNEY
