Luther Ridge
at Middletown

Instructions: Please follow carefully - Incomplete applications will be returned

1. **Complete all areas**. If an item does not apply to you, mark "N/A" on that line.
2. **We need copies of Social Security Cards** The government **requires** that all applicants over the age of 5 submit a copy of their social security card with the attached housing application. If you do not have a social security card, we can accept one of the following, as long as your social security number appears on the document.

   Driver's License **Medicare Card** **Medical Insurance Card**
   Bank Statement **Retirement benefit letter** **Benefit letter from government agencies**

   Note: Copies of Metal Social Security Cards are not acceptable.

   If you cannot provide us with any of the above documents, it will be necessary that you certify to us that you have made application to the Social Security Office for a new card before we will accept your housing application.
3. **Proof of US Citizenship** The US Department of Housing & Urban Development **requires** that all applicants be US Citizens, nationals or certain categories of eligible noncitizens. To do this, you **must** have the attached Declaration of Section 214 Status forms completed by **EACH** family member (including yourself). Please make sure you follow the instructions on the Declaration Form.
4. **Signatures are required by all adult applicants**
5. **Return your application to:**

Lutheran Assisted Living at Middletown
628 Congdon Street West
Middletown CT 06457

Your application is being returned because:

- ☐ **You did not complete all areas or you did not sign the application.**
- ☐ **You did not provide the required social security cards for all household members over the age of 5.**
- ☐ **The Declaration of Section 214 Status and Family Summary Sheet were not completed/signed as instructed above.**

Please return your application along with the information that was missing if you want to be considered for Assisted Living.

Lutheran Assisted Living at Middletown**USE ONLY:** **DATE RECEIVED:** _____ **TIME RECEIVED:** _____
ID #:

APPLICATION FOR ASSISTED HOUSING – (ASSISTED LIVING)

- If the information provided by or about any applicant from any source at any time during the screening process reveals negative information relating to the applicant's ability to meet the obligations of tenancy, the information will be researched as part of the tenant selection screening process and that applicant will be asked to explain this information as part of a uniformly applied policy applicable to all applicants.
- All applicants must be able to meet essential obligations of tenancy -- they must be able to pay rent, to care for their apartment, to report required information to Lutheran Assisted Living at Middletown, to avoid disturbing their neighbors, etc., but there is no requirement that they be able to do these things without assistance.

Lutheran Assisted Living at Middletown is a management company that provides low rent housing to eligible households, elderly households and single people. Lutheran Assisted Living at Middletown is not permitted to discriminate against applicants on the basis of their race, color, religion, sex, national origin, disability handicap or familial status. In addition Lutheran Assisted Living at Middletown has a legal obligation to provide "reasonable accommodations" to applicants if they, or any household member, have a disability or handicap.

- A reasonable accommodation is some modification or change Lutheran Assisted Living at Middletown can make to its apartments or procedures that will assist an otherwise eligible applicant with a disability to take advantage of government programs.

- The Fair Housing Act/Federal law prohibits discrimination in the sale, rental or financing of housing on the basis of race, color, national original, sex, religion, age, disability, marital or familial status. USDA, Rural Development applicants may file any complaints of discrimination to USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice or TDD). Section 8 applicants may file any complaints of discrimination to the U.S. Dept. of Housing & Urban Development, Assistant Secretary for Fair Housing & Equal Opportunity, Washington DC 20410.

A. **FAMILY SUMMARY** -List all persons, including yourself, who will be living in the apartment. List head of household first.

Name – including MIDDLE NAME	Relationship	Gender	Soc Sec #	Birth Date	Place of Birth
1	Head				
2					

Mailing Address: City: State: Zip:

Physical Address: (if different than mailing address) City: State: Zip:

Telephone No. (which you can be reached at): _____ E-Mail Address _____

Applying to Property(s): _____ Requested Unit Size: _____ **Bedrooms**

How did you hear about the apartment for which you are applying? _____

If you require any modifications to an apartment, check here and explain in a note to us ☐

Are you currently enrolled in the Connecticut Homecare Program for Elders? _____
Are you currently on Title XIX (Title 19)? _____
If no, have you filed an application for Title XIX? _____

Are you a Veteran? _____ **If yes, please list branch of military** _____

B. **INCOME - All sources of regularly received monies must be listed regardless of recipient's age.**

Family Member Name	Sources of Income	Amount
	Social Security Gross Monthly Amount	$
	Social Security Gross Monthly Amount	$
	Pension Gross Monthly Amount	$
	Source:	
	Address:	
	Claim No.	
	Pension Gross Monthly Amount	$
	Source:	
	Address:	
	Claim No.	
	VA Benefits (Claim #)	$
	SSI Benefits Gross Monthly Amount	$
	Unemployment Compensation Gross Monthly Amount	$
	Address:	
	Wages Gross Monthly Amount	$
	Employer:	
	Address:	
	Wages Gross Monthly Amount	$
	Employer:	
	Address:	
	Alimony Gross Monthly Amount Other Income Gross Monthly Amount (for example, rental income, etc.)	$
		$
		$

C. **ASSETS**:

Have you sold or disposed of any asset(s) valued over $1,000 in the last two years? Yes_____ No_____

If yes, type of asset (e.g., money/land/house) _____

Market value when sold/disposed $_____ Amount sold/disposed for $_____ Date of transaction _____

C. **ASSETS** (continued)

Provide the following information for all members of the household (use another sheet of paper if necessary).

Checking Accounts

Bank	Bank
Address	Address
Account No.	Account No.
Int. Rate Balance $	Int. Rate Balance $

Savings Accounts

Bank	Bank
Address	Address
Account No.	Account No.
Int. Rate Balance $	Int. Rate Balance $

Certificates of Deposit

Bank	Bank
Address	Address
Acct.# Int Rate Amt. $	Acct.# Int Rate Amt. $
Penalty for Early Withdrawal Maturity Date	Penalty for Early Withdrawal Maturity Date

Stocks

Name
Address
Value $ Div. Rate

IRA's/401-K's

Bank
Address
Value $ Div. Rate

Bonds

Bank
Address
Present Value $
Maturity Date

Trust Accounts

Bank
Address
Account No.
Int. Rate Balance $

C. **ASSETS** (continued):

Real Estate

Do you own any property? Yes_____ No_____

If yes, type & location of property _____

_____

Appraised market value $_____ Mortgage or outstanding loan due $_____

Name & address of broker/realtor who would provide verification of market value:

_____

Broker/Realtor **Address** **City** **State** **Zip**

D. **MEDICAL AND CHILD CARE EXPENSES**

FOR ELDERLY, DISABLED, HANDICAPPED APPLICANTS ONLY

Medical Costs - Complete only if head or spouse is 65 or older, handicapped, or disabled AND ONLY if these medical expenses are paid for out of your own pocket and not reimbursed by medical insurance.

Medicare

Monthly Amount $	Monthly Amount $

Medical Insurance

Name	Name
Address	Address
Claim No. Monthly Amt. $	Claim No. Monthly Amt. $

Pharmacy

Name	Name
Address	Address
Anticipated prescription costs **not covered by insurance** - Monthly Amount $	Anticipated prescription costs **not covered by insurance** - Monthly Amount $

Physician

Are you seeing a physician **REGULARLY**? Yes_____ No_____	
Name	Name
Address	Address
Anticipated costs **not covered by insurance** - Monthly Amount $	Anticipated costs **not covered by insurance** - Monthly Amount $

Outstanding Medical Bills for which You are Making Monthly Payments

Name	Name
Address	Address
Anticipated costs **not covered by insurance** - Balance Due $ Monthly Amount $	Anticipated costs **not covered by insurance** - Balance Due $ Monthly Amount $

E. **PROGRAM INFORMATION**

Are you currently living in subsidized housing? Yes_____ No_____

F. **APPLICANT INFORMATION-Please place a checkmark in the box if any of the following statements apply to you.**

1. You have been served a Notice to Quit or been asked to leave by a previous landlord ☐
2. You have been served with lease violations from a previous landlord ☐
3. You have been evicted ☐
4. You or any household member have been evicted from federally assisted housing for drug-related criminal activity? ☐

If you checked any of the above boxes, please explain the circumstances on an attached sheet of paper and identify property & landlord.

5. You or a household member have been convicted of a sex related crime or are subject to a lifetime registration in a State sex offender registration program? ☐

   List all states, other than the one that you reside in now, in which you have lived in during the last seven years? _____

G. **REFERENCE INFORMATION**

Current Landlord (Name, Address,& Phone No.)

_____

How long have you lived there? _____ Is this landlord related to you? Yes____ No____

List all Previous Landlords for ALL Adults in Household (Attach a sheet of paper if more space is needed.) (Name, Address & Phone No.)

1.	2.
Address of Apt.	Address of Apt.
How long did you live there?	How long did you live there?
Is this landlord related to you? Yes____ No____	Is this landlord related to you? Yes____ No____

List two Professional Personal References for ALL Adults in Household (Attach a sheet of paper if more space is needed.) (Name, Address, Phone No. & Relationship)

(Example: teachers, principals, past/present employers, physicians, etc.) Please do not list relatives or friends.

1.	2.
Phone No. Relationship	Phone No. Relationship

All information received by Lutheran Assisted Living at Middletown during the application process regarding the applicant or applicant's household will be taken into consideration as part of the application.

Luther Ridge
at Middletown

Authorization for Verification of Credit and Criminal History

"I _____ hereby authorize Luther Ridge to obtain a consumer report, and any other information it deems necessary, for the purpose of evaluating my application for housing. I understand that such information may include, but is not limited to, credit history, civil and criminal information, records of arrest, rental history, employment/salary details, vehicle records, licensing records, and/or other information. I hereby expressly release Luther Ridge, and any procured or furnisher of information, from any liability what-so-ever in the use, procurement, or furnishing of such information, and understand that my application information may be provided to various local, state and/or federal government agencies, including without limitation various law enforcement agencies".

Signature:_____

Date:_____

628 Congdon Street West , Middletown, Connecticut 06457 Tel: (860) 347-7144

AUTHORIZATION TO RELEASE INFORMATION

RE: Applicant/Tenant: _____ Unit # _____

Property Name: Lutheran Assisted Living

Address: 628 Congdon St West

Middletown, CT 06457

As managing agents for this Low Income Housing Tax Credit Project, Federal Regulations require we verify the program eligibility of all members of families applying for admission and verify this information periodically for residents. To comply with this requirement, your cooperation is needed in supplying the information requested. This information will be held in strict confidence for use in determining eligibility status and income for this family. A signed authorization for your release appears below. Please complete the attached form and return it to the address above at your earliest convenience. Thank you for your assistance.

_____ Housing Manager

Authorized Signature — Title

Amy Rosado _____

Print Name — Date

Release by Applicant/Tenant

I hereby authorize the release of all requested information.

_____ _____

Signature — Date

Verification form is attached.

Exhibit 3-5: **Sample Citizenship Declaration **

INSTRUCTIONS: Complete this Declaration for each member of the household listed on the Family Summary Sheet

LAST NAME_____

FIRST NAME_____

RELATIONSHIP TO HEAD OF HOUSEHOLD _____ SEX _____ DATE OF BIRTH _____

SOCIAL SECURITY NO._____ ALIEN REGISTRATION NO._____

ADMISSION NUMBER_____if applicable (this is an 11-digit number found on DHS Form I-94, *Departure Record*)

NATIONALITY _____ (Enter the foreign nation or country to which you owe legal allegiance. This is normally but not always the country of birth.)

SAVE VERIFICATION NO._____
(to be entered by owner if and when received)

INSTRUCTIONS: Complete the Declaration below by printing or by typing the person's first name, middle initial, and last name in the space provided. Then review the blocks shown below and complete either block number 1, 2, or 3:

DECLARATION

I, _____ hereby declare, under penalty of perjury, that I am _____
(print or type first name, middle initial, last name):

_____ 1. A citizen or national of the United States.

Sign and date below and return to the name and address specified in the attached notification letter. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

_____ 2. A noncitizen with eligible immigration status as evidenced by one of the documents listed below:

NOTE: If you checked this block and you are 62 years of age or older, you need only submit a proof of age document together with this format, and sign below:

If you checked this block and you are less than 62 years of age, you should submit the following documents:

a. Verification Consent Format (**see Sample Verification Consent Form in Exhibit 3-6**).

AND

b. One of the following documents:

(1) Form I-551, *Alien Registration Receipt Card* (for permanent resident aliens).

(2) Form I-94, *Arrival-Departure Record*, with one of the following annotations:

(a) "Admitted as Refugee Pursuant to section 207";

(b) "Section 208" or "Asylum";

(c) "Section 243(h)" or "Deportation stayed by Attorney General"; or

(d) "Paroled Pursuant to Sec. 212(d)(5) of the INA."

(3) If Form I-94, *Arrival-Departure Record*, is not annotated, it must be accompanied by one of the following documents:

(a) A final court decision granting asylum (but only if no appeal is taken);

(b) A letter from an DHS asylum officer granting asylum (if application was filed on or after October 1, 1990) or from an DHS district director granting asylum (if application was filed before October 1, 1990);

(c) A court decision granting withholding or deportation; or

(d) A letter from an DHS asylum officer granting withholding of deportation (if application was filed on or after October 1, 1990).

(4) Form I-688, *Temporary Resident Card*, which must be annotated "Section 245A" or "Section 210."

(5) Form I-688B, *Employment Authorization Card*, which must be annotated "Provision of Law 274a.12(11)" or "Provision of Law 274a.12."

(6) A receipt issued by the DHS indicating that an application for issuance of a replacement document in one of the above-listed categories has been made and that the applicant's entitlement to the document has been verified.

(7) Form I-151 Alien Registration Receipt Card.

If this block is checked, sign and date below and submit the documentation required above with this declaration and a verification consent format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

If for any reason, the documents shown in subparagraph 2.b. above are not currently available, complete the Request for Extension block below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

REQUEST FOR EXTENSION

I hereby certify that I am a noncitizen with eligible immigration status, as noted in block 2 above, but the evidence needed to support my claim is temporarily unavailable. Therefore, I am requesting additional time to obtain the necessary evidence. I further certify that diligent and prompt efforts will be undertaken to obtain this evidence.

_____ _____
Signature Date

Check if adult signed for a child: _____

_____ 3. I am not contending eligible immigration status and I understand that I am not eligible for financial assistance.

If you checked this block, no further information is required, and the person named above is not eligible for assistance. Sign and date below and forward this format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who is responsible for the child should sign and date below.

_____ _____
Signature Date

Check here if adult signed for a child: _____

FAX: (860) 347-3942

Luther Ridge
at Middletown
628 Congdon Street West
Middletown, CT 06457

PHYSICIAN'S REPORT - APPENDIX 1

Patient's Name: _____ Age: _____

Address: _____

City: _____ State: ___ Zip Code: _____

Dear Doctor,

Your patient wishes to join us at the Luther Ridge Assisted Living Facility. As you know, Assisted Living is a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living. This facility provides individual accommodation~ with private kitchen and bath facilities; three meals a day; housekeeping services; weekly laundry services; and a staff member on site 24 hours a day. In addition, your patient will be receiving assisted living services from a licensed Assisted Living Services Agency (ALSA).

As part of the application process, we need a physician report completed. **This report must be completed by a primary care physician who intends to follow this patient and is willing to update orders every 120 days.** We ask that you complete each item on this form and return it to us with any other pertinent comments you deem appropriate. The confidential information you provide will be used by our professional staff during our assessment for eligibility and used by the ALSA provider to identify the appropriate level of assisted living services, and to initiate a care plan.

It is important that each resident be chronic and stable. These services are designed to help provide assistance to residents who need additional help, but do not need a skilled nursing facility. The resident will need to be able to maintain himself/herself in an independent manner without endangering either themselves or others in order to benefit from our facility. It is equally important that each resident be emotionally stable, suited to and capable of residential community living, since the welfare and peace of mind of many residents are involved. This information is CONFIDENTIAL. If you have any questions, please feel free to call **Caroline Fiderio, RN** at **(860) 347-7144**. Thank you in advance for your cooperation.

Date of Birth: _____ Date of Last Office Visit: _____

Drug or other allergies: _____

Does your patient have a history of:

			Comments:
Alzheimer's Disease	☐ No	☐ Yes	_____
Asthma or Allergy	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
Cerebrovascular	☐ No	☐ Yes	_____
Dementia	☐ No	☐ Yes	_____
Depression	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Emphysema	☐ No	☐ Yes	_____
Epilepsy	☐ No	☐ Yes	_____
Gastrointestinal	☐ No	☐ Yes	_____
Glaucoma	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Hypertension	☐ No	☐ Yes	_____
Kidney Disease	☐ No	☐ Yes	_____
Liver Disease	☐ No	☐ Yes	_____
Osteoporosis	☐ No	☐ Yes	_____
Parkinson's Disease	☐ No	☐ Yes	_____
Respiratory Disease	☐ No	☐ Yes	_____
Thyroid Disease	☐ No	☐ Yes	_____

Current or recent (within 6 months) problems with:

Arthritis	☐ No	☐ Yes
Appetite, poor	☐ No	☐ Yes
Chronic back pain	☐ No	☐ Yes
Fainting	☐ No	☐ Yes
Falls	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Indigestion	☐ No	☐ Yes

Jaundice	☐ No	☐ Yes
Loss of weight	☐ No	☐ Yes
Nausea or Vomiting	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Psychiatric illness	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Urinary retention	☐ No	☐ Yes
Urinary Incontinence	☐ No	☐ Yes

Hospitalizations: (During the past 5 years)

Date:	Cause:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History:

Regarding the questions below: If "yes" or "no" provides adequate meaning, please use it. If a descriptive phrase will convey more useful information, we would appreciate the phrase.

Regarding your Patient:

a. Do you detect any condition or disease that **currently** requires care from a skilled Long-term facility at this time? _____

b. Is your patient's medical condition chronic and stable and are they able to live independently with support from the assisted living agency?

_____

_____

***Please complete the following:**

Check here if exhibiting TB-like symptoms: ☐

If TB skin test is 10 mm or greater (5mm in the HIV infected) previously positive or if TB-like symptoms exist, respond to the following:

a. Date of last Chest X-Ray evaluation: _____

b. Are chest x -rays suggestive of active TB? ☐ No ☐ Yes

c. Were sputum smears collected and analyzed for presence of acid fast bacilli (AFB)?
☐ No ☐ Yes

d. If "c" above is "Yes," were three consecutive smears negative for AFB?
☐ No ☐ Yes

Based on the above information, is this individual free of communicable TB? ☐ No ☐ Yes

****

I have completed the medical history section, and have determined that my patient named above is chronic and stable and qualifies for assisted living services provided by Luther Ridge.

_____ _____

Physician Signature Date

_____ _____

Physician Name Printed Telephone

_____ _____

Address Fax

_____

City State Zip Code

Applicants, Families, and Physicians:

This report may need to be updated based on the availability of an apartment. Please include a list of current medications (see last page).

Thank you,

Caroline Fiderio, RN, Luther Ridge Supervisor of Assisted Living Services

Phone: (860) 347-7144 ext. 119 Fax: (860) 347-3942

Current Medications (including dose and frequency):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Physician's Signature Physician's Name – Printed

_____ _____

Date Telephone number

NOTE: If you are attaching a medication list, please sign and date the attached information. Thank you.