General Assistance Application

Items checked are **required** to complete this application.

<table>
<thead>
<tr>
<th>Rcvd</th>
<th>Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐ Rcvd Client Application completed by person in charge of household earnings or benefits.</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked Valid Driver’s License, State Picture ID Card for <strong>ALL</strong> Adults</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked Children’s Birth Certificate or Children’s Immunization Records</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked Proof of all monies received within the last 30 days for <strong>ALL</strong> household members such as, Payroll Stubs, Child Support, Unemployment, TANF, SSA, SSI, SSDI</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked Bank Statements (for last 30 days)</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked Rental Lease Agreement and Last Paid Rent Receipt (for proof of residency)</td>
</tr>
<tr>
<td>☐</td>
<td>☐ Checked <strong>CURRENT</strong> Heating &amp; Electrical Utility Bills in your name (for proof of residency)</td>
</tr>
</tbody>
</table>

*****

Determination and Appeal Process

1. After notification, the person denied assistance may request a hearing in writing within 30 days from the date of the issuance of denial. The hearing must be conducted by the manager or her designee, but must not be the employee or representative of the county whom investigated or made the initial decision to deny your assistance.

2. A decision adverse to the person denied assistance must be in writing and set forth the factual basis for the decision and the applicable regulation. A copy of the decision must be served personally or by certified mail upon each party and his representative.

3. A person aggrieved by the final decision of the county may, within 30 day after the date on which written notice of the decision is served or mailed, petition the district court where he resides to review the decision.

Determinación y Proceso de Apelación

1. Después de la notificación, la persona a la que fue negada la asistencia puede pedir una audiencia por escrito dentro de los siguientes 30 días desde la fecha en que se le fue rechazado(a). La audiencia debe realizarse por el administrador o representante asignado, pero no debe ser el empleado o representante del Condado quien investigó o tomó la decisión inicial de negar su asistencia.

2. Una decisión adversa a la persona a la cual se le negó asistencia debe ser por escrito y establecer la base factual de la decisión y la regulación aplicable. Una copia de la decisión debe ser entregada personalmente o por correo certificado a cada partido y su representante.

3. Una persona perjudicada por la decisión final del Condado, dentro de los siguientes 30 días después de la fecha en la que se le entregó o recibió por correo el informe de la decisión, Puede solicitar al tribunal del distrito donde reside una reevaluación de la decisión.
<table>
<thead>
<tr>
<th><strong>Head of Household</strong></th>
<th><strong>Middle Name</strong></th>
<th><strong>Last Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

-  -  -  (  )  000 -00 -

Date of Birth:  
Age:  
Last 4 Digits of Social Security Number

**Gender:**  
☐ Male  
☐ Female  
**Maiden Name:**  

**Place of Birth:**

**US Citizen:**  
☐ Yes  
☐ No  
☐ Disabled  
☐ Military Veteran

**Ethnicity:**  
☐ Hispanic  
☐ Non-Hispanic

**RACE:**  
☐ White  
☐ Latino  
☐ Black or African American  
☐ Native American-Alaskan Native  
☐ Asian  
☐ Middle Eastern  
☐ Pacific Islander  
☐ Other Multi Race  
☐ Black/African American & American Indian/Alaskan Native  
☐ Black/African American & Asian  
☐ Black/African American & White  
☐ White & Asian  
☐ White & American Indian/Alaskan Native  
☐ White & Black/African American & Asian  
☐ White/Black/African American & American Indian

**Family Type/Parental Status:**

- One Parent – Male
- One Parent – Female
- Two Adult with Children
- Two Adult Family – No children
- Single Person – living alone
- Grandparents raising Grandchildren
- Foster Family
- Other

**Marital Status:**

- Married
- Unmarried Partner
- Separated
- Divorced
- Single
- Widowed

**Home Address:** (No PO Box):

- Space 
- Apt 

City:  
State:  
Zip Code:  

**Mailing Address:**

- PO Box/Address  
- City  
- State  
- Zip

**Home/Cell Phone #:**  

- Message 

**Total # of Persons in Household:**

Signed in Office

I certify under penalty of perjury that my answers are correct and complete  ___/___/___

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Education:**

- □ 0-8
- □ 9-12/non graduates
- □ High school grad
- □ GED
- □ Post-Secondary
- □ Associates Degree
- □ Bachelor Degree
- □ Master Degree
- □ Doctorate Degree
- □ Other Graduate/Professional Degree
- □ Certificate of Advance Training
- □ Skilled Artisan

**Additional Household Members (do not include Applicant)**

<table>
<thead>
<tr>
<th>Name (First, Middle &amp; Last)</th>
<th>Gender</th>
<th>Relationship To Head of Household</th>
<th>Birth Date</th>
<th>Educ. Level</th>
<th>Race*</th>
<th>Pregnant Yes / No</th>
<th>Disabled or Veteran</th>
<th>US Citizen</th>
<th>Lasts 4 Numbers of Social Security</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* RACE: 1-White  2-Latino  3-Black or African American  4-Native American-Alaskan Native  5-Asian  6-Middle Eastern  7-Pacific Islander  8-Other Multi Race
  9-Black/African American & American Indian/Alaskan Native  10-Black/African American & Asian  11-Black/African American & White  12-White & Asian
  13-White & American Indian/Alaskan Native  14-White & Black/African American & Asian  15-White & Black/African American and American Indian

**Applicant’s Employer:**

- □ Current  □ Last
- Employer: ____________________________ Employer Location: ____________________________
- □ Full Time  □ Part-Time  □ Seeking Employment  □ Not Seeking Employment  □ Retired
- Rate of Pay: __________ Job Title: ____________________________
- Start Date: __/_/____ End Date: __/_/____ Reason for Leaving: ____________________________
- When are you available to start a job __/_/____?

**Household’s Earned Income:**

<table>
<thead>
<tr>
<th>Household Member :</th>
<th>Employer:</th>
<th>Employment Dates:</th>
<th>Rate of Pay:</th>
<th>Position:</th>
<th>Reason for Leaving:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Begin:</td>
<td>End:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed in Office
I _____________________________________________ certify under penalty of perjury that my answers are correct and complete __/_/____
Household’s Unearned Income:

<table>
<thead>
<tr>
<th>Household Member</th>
<th>Unemployment $</th>
<th>SSI $</th>
<th>SSDI $</th>
<th>SS $</th>
<th>Pension $</th>
<th>Other $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL MONTHLY INCOME FROM ALL MEMBERS OF HOUSEHOLD: $ ______________________

Has anyone in the household sold any property in the last 60 months?  □ No  □ Yes

If Yes: Description: __________________________ Value: $ ______________ Date Sold: ___/___/____

Daycare or Childcare: What arrangement have you made for child care? ____________________________

Children’s Schools:

Child’s Name: _______________ School: _______________ Grade: __________

Child’s Name: _______________ School: _______________ Grade: __________

Child’s Name: _______________ School: _______________ Grade: __________

Any Barriers to Enrolling Children in School: ____________________________

Has anyone in household ever received Rental Assistance (from any agency)?

□ No  □ Yes  If Yes, please answer the following:

When: ___/___/____ Amount: $ ______________ Agency: ____________________________

Has anyone in the household received assistance from Carson City Human Services?

□ No  □ Yes  If Yes, please answer the following:

What type of services? ____________________________ Date of Service: ___/___/____

Does the Household currently have transportation?  □ Yes  □ No

□ Private Vehicle (Make/Model) ____________________________ □ Public Transportation

□ Some other regular arrangement □ Other: ____________________________

Insurance Coverage (Current):

□ Auto Insurance   □ Life Insurance □ Dental Insurance □ Medical Insurance (Check all that apply):

□ Medicaid: Who is covered________________________ □ Medicare □ VA Medical Services

□ Employer Provided □ Spouse □ NV Check-Up □ Private________________________________

Signed in Office

I _____________________________________________ certify under penalty of perjury that my answers are correct and complete ___/___/____
Client Characteristics:

Applicant’s Place of Birth: ________________________________

Mother’s Maiden Name: ________________________________

Barriers/Services Needed (Check all that apply):

☐ Alcohol use - Last time used ________ ☐ Drug use - Last time used ________ ☐ Expect Long-Term Substance use
☐ Mental Illness – Receiving Care ☐ yes ☐ no ☐ Expect Long-Term Mental Illness
☐ Chronic Health Condition
☐ Convicted of a Crime Parole ☐ yes ☐ no
☐ Active HIV/AIDS ☐ Other Special Needs (please specify) ________________________________

Experienced Domestic Violence: ☐ Yes ☐ No
If Yes, when:
☐ Less than 3 months ago ☐ 3-6 months ago ☐ 6-12 months ago
☐ More than 1 year ago ☐ I refuse to answer

*HUD considers chronic homelessness is living in someone else’s home or in a motel/hotel*

Are You At Risk of Homelessness? ☐ Yes ☐ No
Are you homeless now? ☐ Yes ☐ No
Were You Homeless before 18? ☐ Yes ☐ No
Have you been homeless more than 3 times in a year? ☐ Yes ☐ No

Cause of Homelessness: (Check all that apply)

☐ Not Homeless ☐ New to Area ☐ New to Area-No Deposit money
☐ New to Area-No Social Supports ☐ Financial ☐ Credit Problems
☐ Gambling ☐ Unable to get Job ☐ Eviction-Loss of Housing
☐ Eviction-Non-Financial Reasons ☐ Eviction-Non-Payment ☐ Fire or Condemnation
☐ Previous Eviction/Non-Payment of Utilities ☐ Medical or Social Problems
☐ Domestic Violence ☐ Drug or Alcohol Problems ☐ Incarceration
☐ Medical Problems-Non-Mental ☐ Mental Health Problems

Prior Living-Type of Housing Situation:

☐ Place not Habitation (Streets) ☐ Emergency Shelter
☐ Transitional Housing ☐ Permanent Housing for Former Homeless
☐ Psychiatric Facility/Hospital ☐ Substance Abuse Treatment Facility
☐ Hospital (Non-Psychiatric) ☐ Jail or Juvenile Detention
☐ Domestic Violence Situation ☐ Living with Family/Relatives
☐ Living with Friends ☐ Rented Room/Apartment/House
☐ Hotel/Motel ☐ Foster Care Family/Group Home

Duration of Prior Living Situation:

☐ 1 week ☐ Over 1 week-1 month ☐ 1-3 months
☐ Over 3 months-1 year ☐ 1 year or more

Zip code of last permanent address: ____________

_________________________________________ certify under penalty of perjury that my answers are correct and complete ____/____/____
For Veterans Only:

☐ I am not a veteran (If not a Veteran please go to the next page)

Branch of Service
☐ Air Force    ☐ Navy
☐ Army        ☐ Other
☐ Marines     ☐ Unknown

Duration of Active Duty [Months] ____________

Served in War Zone
☐ Yes
☐ No

War Zone of Service
☐ Afghanistan
☐ China, Burma, or India
☐ Europe
☐ Korea
☐ Laos or Cambodia
☐ North Africa
☐ Persian Gulf
☐ South China Sea
☐ South Pacific
☐ Vietnam
☐ Refused
☐ Other

Duration of War Zone Service [Months] ____________

Era of Service
☐ Post September 11, 2001 (September 11, 2001 to Present)
☐ Persian Gulf Era [Aug ’91 to Present]
☐ Post-Vietnam Era [May ’75 to July ’91]
☐ Vietnam Era [Aug ’64 to April ’75]
☐ Korea to Vietnam [Aug ’64 to April ’75]
☐ Korean War [June ’50 to Jan ’55]
☐ WW2 to Korean War [Aug ’47 to May ’50]
☐ World War II [Sept ’40 to July ’47]
☐ WW1 to WW2 [Dec ’18 to Aug ’40]
☐ Other Era of Service
☐ Not Applicable
☐ Unknown

Discharge Status
☐ Honorable
☐ General [Under Honorable Conditions]
☐ Medical Discharge
☐ Under Other than Honorable Conditions
☐ Entry Level Separation [ELS]
☐ Bad Conduct Discharge [BCD]
☐ Dishonorable Discharge [DD]
☐ Refused
☐ Unknown

Signed in Office
I ___________________________________________certify under penalty of perjury that my answers are correct and complete ___/___/____
### Unearned Income:

<table>
<thead>
<tr>
<th>UNEARNED INCOME</th>
<th>RECEIVING</th>
<th>APPLIED FOR</th>
<th>WHO</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Child Support/ Alimony</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>2) Unemployment Benefits or Worker’s Compensation</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3) Secured Supplemental Retirement Income (SSI)</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4) Secured Supplemental Disability Income (SSDI)</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5) Food Stamps</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>6) WIC</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>7) Income Grants or Assistance [TANF or Foster Care, etc.]</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>8) Veteran Benefits</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Pension or Disability</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>9) Indian General Assistance</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>10) Military Allotment</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>11) Money from Relatives</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>12) Retirement Pensions [Civil Service, Railroad, Military, Public, Employee, Private or Union, Etc.]</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>13) Money From Property [Rentals or Lease]</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>14) Utility Allowance/ EAP</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>15) Rent from Boarder/Roomers</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>16) Section 8/ HUD Rental Assistance</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>17) Any Other Income Benefit Type:</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Signed in Office

__________________________________________
certify under penalty of perjury that my answers are correct and complete ____/____/____
## Assets and Resources:

- Savings Account Balance: $ ________
- Credit Union Balance: $ ________
- Savings Bond
- **Vehicle[s]** Year/Make/Model: ____________
- Stocks/Bonds Interest: $ ________
- Individual Retirement Accounts [IRA]
- Certificates of Deposit [CD]
- Individual Indian Money Account [IIMA]
- Other House, Land or Building
- Life Estates / Life Leases
- Land / Mineral Rights
- Business Checking Account
- Livestock / Horses
- Burial Funds
- Savings Bond
- Life Insurance Policies
- **Cash on Hand** Amount: $__________
- Trust Funds
- Keogh Accounts [401k]
- Christmas Club Accounts
- Other Account Type: $__________
- Promissory Note or Contracts
- Mining Claims
- Safe Deposit Boxes
- Business Deposit Boxes
- Business Equipment / Inventory
- Other: ________________________

## MONTHLY EXPENSES:

<table>
<thead>
<tr>
<th>Type</th>
<th>Monthly</th>
<th>Your Share</th>
<th>Company Name [Who bill is paid to]</th>
<th>Who Else Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cable / Satellite</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car Payment</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Cards</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garbage / Trash</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gas/Propane/Wood Heating</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortgage/Rent</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space/Lot Rent</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone/Long Distance</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water/Sewer</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed in Office

I ___________________________________________ certify under penalty of perjury that my answers are correct and complete ____/____/____
Consent to the Release and Affirmation of Information

____ I understand information provided on this application is subject to verification by Federal, State or local officials. If any information is found inaccurate, I may be denied assistance and/or be subject to criminal prosecution for knowingly providing false information.

____ I understand the questions on this application and the penalty for hiding or giving false information. I certify under penalty of perjury that my answers are correct and complete. I agree to notify the agency where I made application for assistance of any changes in my circumstances that may affect my eligibility.

____ I understand I have a duty to inform Carson City Human Services if I, or anyone on my behalf, commence a legal action against anyone for recovery of money as reimbursement for medical care and treatment paid for by the county. I must further advise Carson City County Human Services should I or anyone on my behalf, solicit or receive any offer of settlement of money as reimbursement for medical care and treatment paid for by the Medicaid Program and/or county.

____ I hereby authorize the agency to which I am applying for assistance to make any investigation concerning me or other members of my household, or my children’s legal/punitive parent(s) whom is necessary to determine eligibility for any benefit I have, receive or will receive under programs administered by this agency. I hereby authorize and consent to the release of any and all information concerning me or my household members to the agency, by the holder of the information, regardless of the manner of form held, including, without limitation, information made confidential by law, or otherwise, and patient information privileged under NRS 49.225 or any other provision of law, or otherwise. I hereby release the holder of the information liability, if any, resulting from the disclosure of the required information. I authorize the agency to contact my employer to obtain wage information. A reproduced copy of this application, and authorization, legally constitutes an original copy.

____ I authorize the State of Nevada Welfare Division, County Welfare Department and agencies for which I may be eligible for assistance, to exchange information essential for effective case management.

____ I understand that all of the information provided on the preceding 7 pages of my application are necessary and important in determining my eligibility status and that any change in circumstances may affect my eligibility for assistance; therefore I agree to notify CC Humans Services of any change in circumstances within 5 days of the change.

____ This release is valid for a period of one year from the date of authorization.

________________________________________  __________________________
Applicant’s Signature or Mark                      Date

I agree to act on behalf of the above application, and understand my rights and obligations as a representative and responsible party.

________________________________________  __________________________
Authorized Representative’s Signature              Date

Authorized Representative’s Address    City    State/Zip    Phone Contact

Carson City Health & Human Services
900 E Long Street  •  Carson City, Nevada  89706
Human Services (775) 887-2110 Fax: (775) 887-2539
CONSENT TO USE OF DISCLOSE HEALTH INFORMATION

I authorize Carson City to use and disclose my medical records for the purposes of Treatment, Payment and Health Care Operations.

**Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

**Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

**Health Care Operations** include the necessary administrative and business functions of our office.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Carson City’s ‘Notice of Privacy Practices’ for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the current Notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purpose. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Carson City has already used or disclosed the information in reliance on this Consent and to examine the City’s Notice of Privacy Practices.

---

Signature of Patient or Person Authorized by Law

Printed Name of Patient or Person Authorized by Law

Date

Date
CARSON CITY HUMAN SERVICES
CLIENT WORK SEARCH

Please ask prospective employers to complete the following form as evidence of your search for employment. Be sure that the place of business is hiring for a position you are qualified for. Your application will be verified with the place of business listed, be sure that all phone numbers and contact names can be verified.

**You must complete ten (10) applications.**

If you are applying for Employment Online, print out a copy of the confirmation or the application as proof and attach to this log sheet.

*If we are unable to verify information provided, your assistance will be delayed, possibly denied.*

*Client declares all employment information listed is true and understands if false information is provided they may be ineligible for assistance.*

Print Name: ___________________________________ Signature: ___________________________________

Last four of SS# ___________________________ Phone # ___________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>PRINT Name of Business Position Applied for</th>
<th>PRINT Name of Manager Contacted &amp; Signature</th>
<th>PRINT Business Telephone</th>
<th>Office Use</th>
<th>Verification Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach Copied Online Applications

For Office Use

Copies Made By: ___________________________________ Date: ___________________________

Missing Documents: ___________________________________ Appt Date: ___________________________

*Business Managers: Client gives prospective employers permission to release employment information to this agency.*
Landlord to Complete

Landlord’s Name: ____________________________________________

Mailing Address: ____________________________________________

Apartment Complex Name: _________________________ Phone#: _______________________

Number of Bedrooms: _________________ Square Footage: ____________

Type of Unit:     ☐ 2 & 3 Story Walk up Apartment;     ☐ Mobile Home     ☐ Condo
                     ☐ Duplex                                      ☐ Studio
                     ☐ Other

Location/Accessibility:  ☐ Schools                                      ☐ Grocery Store
                     ☐ Bus route                                      ☐ Etc.  _____________

Amenities:  ☐ Pool                                           ☐ Playground
                     ☐ Laundry Room                              ☐ Covered Parking
                     ☐ Garage                                      ☐ Etc:  _____________

Property Condition:  ☐ Excellent                               ☐ Good
                     ☐ Fair                                          ☐ Poor

Neighborhood Type:  ☐ New                                      ☐ Old
                     ☐ Industrial

Was the Building Built Before 1978?  ☐ Yes  ☐ No  Year it was Built: ____________

Utilities (Type):  ☐ Gas                                      ☐ Electric
                     ☐ Propane                              ☐ Water/Sewage
                     ☐ Trash

Utilities Included:  ☐ Yes                                      ☐ No

What Utilities are Included

in the Rent:  ☐ Gas                                      ☐ Electric
                     ☐ Propane                              ☐ Water/Sewage
                     ☐ Trash

Utility Allowance:  ☐ Yes                                      ☐ No

Unit Rent:  $ ________________

Gross Rent:  $ ________________ Is the Unit Handicap Accessible?  ☐ Yes  ☐ No