

RENTAL APPLICATION (HUD/FmHA)
PLEASE PRINT ALL INFORMATION

DATE: _____ TIME: _____ For Office Use Only

PROPERTY NAME: J. B. MILAM APARTMENTS PRE-OCC # _____

A. APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

CURRENT ADDRESS: _____ APT. NO. _____

CITY, STATE, ZIP: _____

CURRENT LANDLORD: _____ PHONE# (_____) _____

HOW LONG HAVE YOU LIVED AT THIS ADDRESS? _____ CURRENT RENT: \$ _____

HOME PHONE NUMBER:(_____) _____ WORK PHONE NUMBER:(_____) _____

DO YOU PAY THE UTILITIES? _____ HOW MUCH PER MONTH (average) _____

B. HOUSEHOLD COMPOSITION

(LIST HEAD OF HOUSEHOLD AND ALL OTHER HOUSEHOLD MEMBERS WHICH WILL OCCUPY THE APARTMENT YOU ARE APPLYING FOR.)

MEMBERS-FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY#
1	(HEAD)	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

IS THERE A MEMBER 18 OR OLDER THAT IS ATTENDING AN INSTITUTION OF HIGHER EDUCATION? _____ YES
 _____ NO IF YES, WHO? _____

SCHOOL ATTENDING? _____

DOES ANYONE LIVE WITH YOU NOW WHO IS NOT LISTED ABOVE? _____ YES _____ NO

DO YOU HAVE TO HAVE ANYONE LIVING WITH YOU IN THE FUTURE WHO IS NOT LISTED ABOVE? _____ YES
 _____ NO. IF YES, EXPLAIN _____

DO YOU OR ANY HOUSEHOLD MEMBER REQUIRE SPECIAL HOUSING NEEDS? _____ YES _____ NO
 IF YES THE SPEICAL HOUSING NEED QUESTIONNAIRE MUST BE COMPLETED.

ARE YOU OR ANY MEMBER OF YOUR HOUSEHOLD SUBJECT TO A LIFETIME REGISTRATION REQUIREMENT UNDER A STATE SEX OFFENDER REGISTRATION PROGRAM? _____ YES _____ NO



HOW MANY PEOPLE RESIDE IN YOUR HOME? _____ HOW MANY BEDROOMS IN YOUR HOME? _____

WHY DO YOU WISH TO MOVE? _____

ARE YOU BEING EVICTED? _____ IF SO, WHY? _____

WHEN MUST YOU BE OUT OF YOUR HOME? _____

HAVE YOU EVER BEEN EVICTED IN THE PAST? _____ IF SO, FROM WHERE AND WHEN? _____

HAVE YOU LIVED IN SUBSIDIZED HOUSING BEFORE? _____ IF SO, LIST PROPERTY NAME AND ADDRESS: _____

HAS ASSISTANCE EVER BEEN TERMINATED FOR FRAUD _____, NONPAYMENT OF RENT _____, OR FAILURE TO COOPERATE WITH RECERTIFICATION PROGRAM _____?

PRESENT LANDLORD NAME: _____ TELEPHONE NUMBER _____

ADDRESS: _____

FROM: _____ TO: _____ AMOUNT OF RENTAL PAYMENTS _____

FORMER LANDLORD NAME: _____ TELEPHONE NUMBER _____

ADDRESS: _____

FROM: _____ TO: _____ AMOUNT OF RENTAL PAYMENTS _____

D. REFERENCES (PERSONAL: NOT RELATED, MSUT BE ABLE TO CONTACT DURING BUSINESS HOURS)

1) NAME: _____ 2) _____ 3) _____

ADDRESS: _____

PHONE: (____) _____ (____) _____ (____) _____

E. CREDIT INFORMATION (INCLUDE CREDIT CARD ACCOUNTS, BANKS, FINANCE COMPANIES, ETC.)

1 2 3

NAME: _____

ADDRESS: _____

PHONE: (____) _____ (____) _____ (____) _____

ACCT#: _____

DO YOU OWN A CAR? _____ MAKE _____ MODEL _____ YEAR _____

DRIVERS LICENSE#: _____ STATE: _____ EXPIRATION DATE: _____

F. SOURCE(S) OF INCOME

LIST INCOME SOURCES OF ALL HOUSEHOLD MEMBERS WHO WILL OCCUPY THE APARTMENT, THIS INCLUDES BUT IS NOT LIMITED TO, FULL AND/OR PART-TIME EMPLOYMENT, ALL INCOME FROM WELFARE AGENCIES, SOCIAL SECURITY, PENSION, SSI, DISABILITY, ARMED FORCES RESERVES, UNEMPLOYMENT COMPENSATION, CHILD CARE, ALIMONY, CHILD SUPPORT, SCHOLARSHIPS AND GRANTS. CONTRACT FOR DEED, INTEREST ON ASSETS, DIVIDENDS, ANNUITIES AND REGULAR CONTRIBUTIONS FROM PEOPLE NOT RESIDING WITH YOU.

PLEASE CHECK THE APPLICABLE INCOME SOURCE(S) AND INDICATE NAME, ADDRESS, TELEPHONE NUMBER:

____ EMPLOYMENT: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ EMPLOYMENT: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ MILITARY: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ PENSION/ ASSISTANCE: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ UNEMPLOYMENT: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ VETERANS DISABILITY: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ SOCIAL SECURITY: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ OTHER: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

____ OTHER: NAME _____ TELEPHONE NO (____) _____
ADDRESS _____
ANNUAL GROSS INCOME TO YOU _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS, FOR EACH (YES) ANSWER, PROVIDE ACCURATE

INFORMATION IN THE CHARTS PROVIDED.

- | | YES | NO |
|-------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|
| 1. DOES ANY MEMBER OF YOUR FAMILY WORK FOR SOMEONE WHO PAYS THEM IN CASH? | _____ | _____ |
| 2. IS ANY MEMBER OF YOUR HOUSEHOLD ON A LEAVE OF ABSENCE FROM WORK DUE TO LAYOFF, MEDICAL MATERNITY, OR MILITARY LEAVE? | _____ | _____ |
| 3. IS ANY MEMBER OF YOUR FAMILY RESIDING, OR NOT RESIDING IN YOUR HOUSEHOLD, NOW RECEIVING MILITARY PAY AND/OR ALLOWANCES? | _____ | _____ |
| 4. DOES ANY MEMBER OF YOUR HOUSEHOLD RECEIVE OR EXPECT TO RECEIVE CHILD SUPPORT? | _____ | _____ |
| 5. IS ANY MEMBER OF YOUR HOUSEHOLD ENTITLED TO CHILD SUPPORT THAT HE/SHE IS NOT RECEIVING? | _____ | _____ |
| 6. DOES ANY MEMBER OF YOUR HOUSEHOLD RECEIVE OR EXPECT TO RECEIVE ALIMONY? | _____ | _____ |
| 7. IS ANY MEMBER OF YOUR HOUSEHOLD ENTITLED TO ALIMONY PAYMENTS THAT HE/SHE IS NOT NOW RECEIVING? | _____ | _____ |
| 8. DOES ANY MEMBER OF YOUR FAMILY/HOUSEHOLD RECEIVE OR EXPECT TO RECEIVE INCOME FROM A PENSION OR ANNUITY? | _____ | _____ |
| 9. DOES ANY MEMBER OF YOUR FAMILY/HOUSEHOLD RECEIVE REGULAR CASH CONTRIBUTIONS FROM INDIVIDUALS NOT LIVING IN THE UNIT, OR FROM AGENCIES? | _____ | _____ |

G. NET FAMILY ASSETS

_____ CHECKING ACCOUNT: NAME OF BANK _____
 ADDRESS _____

ACCOUNT NUMBER: _____ IS ACCOUNT INTEREST BEARING? _____

CURRENT BALANCE: _____

_____ SAVINGS ACCOUNT: NAME OF BANK _____
 ADDRESS _____

ACCOUNT NUMBER: _____ IS ACCOUNT INTEREST BEARING? _____

CURRENT BALANCE: _____

WILL PART OF THIS CURRENT BALANCE BE USED FOR YOUR SECURITY DEPOSIT? _____ YES _____ NO

IF YES, PLEASE INDICATE AMOUNT \$ _____

_____ STOCKS: NAME _____ TYPE _____

CURRENT MARKET VALUE \$ _____ YEARLY INCOME GENERATED \$ _____

_____ BONDS: NAME _____ TYPE _____

CURRENT MARKET VALUE \$ _____ YEARLY INCOME GENERATED \$ _____

_____ REAL ESTATE: TYPE _____ CURRENT MARKET VALUE \$ _____

AMOUNT OF EXISTING MORTGAGE \$ _____

YEARLY INCOME GENERATED \$ _____

DO YOU OWN A HOME OR OTHER REAL PROPERTY? _____ YES _____ NO

HAVE YOU SOLD OR GIVEN AWAY REAL PROPERTY OR OTHER ASSETS WITHIN THE LAST TWO YEARS?

_____ YES _____ NO IF YES, EXPLAIN _____

WHAT WAS THE MARKET VALUE? \$ _____ AMOUNT ASSET WAS SOLD FOR \$ _____

LIST OTHER ASSETS:

1. TYPE: _____ CURRENT MARKET VALUE \$ _____

YEARLY INCOME GENERATED \$ _____
2. TYPE: _____ CURRENT MARKET VALUE \$ _____
YEARLY INCOME GENERATED \$ _____

H. CHILD CARE EXPENSES (TO BE COMPLETED FOR CHILDREN 12 YEARS OF AGE OR YOUNGER)

DO YOU PAY FOR CHILD CARE DUE TO EMPLOYMENT? _____ AMOUNT OF WEEKLY EXPENSE \$ _____

DO YOU PAY FOR CHILD CARE DUE TO ATTENDING SCHOOL? _____ AMOUNT OF WEEKLY EXPENSE \$ _____

LIST THE NAME(S) AND AGE(S) OF CHILD(REN) FOR WHICH YOU PAY CHILD CARE EXPENSES:

NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____
NAME _____	AGE _____

INSTITUTION OR INDIVIDUAL PROVIDING CHILDCARE

NAME _____

ADDRESS _____

IS CHILD CARE COST COVERED BY AFCD OR ANY OTHER SOURCE? _____

I. HANDICAPPED ASSISTANCE EXPENSES (TO BE COMPLETED ONLY IF THE HANDICAPPED EXPENSE ALLOWS THE HANDICAPPED INDIVIDUAL OR ANOTHER HOUSEHOLD MEMBER TO WORK.)

AMOUNT OF WEEKLY EXPENSE \$ _____

INDICATE THE NAME AND ADDRESS OF THE INDIVIDUAL FOR WHICH YOU PAY HANDICAPPED ASSISTANCE:

NAME _____

ADDRESS _____

J. MEDICAL EXPENSES (TO BE COMPLETED ONLY IF HEAD OF HOUSEHOLD OR SPOUSE IS 62 OR OLDER, DISABLED, OR HANDICAPPED.)

DO YOU HAVE MEDICARE? _____ DO YOU HAVE OTHER MEDICAL INSURANCE? _____ IF YES, INDICATE

NAME _____ POLICY NUMBER _____

DOES MEDICAL ASSISTANCE PAY YOUR DOCTOR AND DRUG BILLS? _____

ARE YOU RECEIVING MEDICAL ASSISTANCE THROUGH WELFARE? _____

IF YOU PAY ANY PORTION OF THE MEDICAL/DRUG COSTS, YOU SHOULD SUPPLY US WITH THE BILLS AND THE RECORDS OF WHAT EXPENSES YOU HAVE INCURRED.

IF YOUR MEDICAL CONDITION IS PERMANENT AND YOU WILL **ROUTINELY** HAVE MEDICAL EXPENSES THAT ARE NOT COVERED BY MEDICARE, MEDICAID OR MEDICAL INSURANCE, PLEASE INDICATE THE TYPE OF MEDICAL EXPENSE, THE FREQUENCY OR THE EXPENSE, AND THE AMOUNT OF THE EXPENSE:

TYPE: _____ FREQUENCY _____ AMOUNT _____

TYPE: _____ FREQUENCY _____ AMOUNT _____

TYPE: _____ FREQUENCY _____ AMOUNT _____

TYPE: _____ FREQUENCY _____ AMOUNT _____

DO YOU UNDERSTAND THAT ALL INCOME, ASSETS AND EXPENSES MUST BE VERIFIED? _____ YES _____ NO

DO YOU UNDERSTAND THAT YOU ARE RESPONSIBLE TO REPORT ALL INCOME OF HOUSEHOLD? _____ YES _____ NO

DO YOU UNDERSTAND THAT YOU ARE TO REPORT ANY CHANGES IN INCOME OR EXPENSES TO THE RENTAL OFFICE AS SOON AS THEY OCCUR? _____ YES _____ NO

K. PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____ PHONE(_____) _____

ADDRESS: _____ RELATIONSHIP _____

L. NON-DISCRIMINATION: (PROPERTY MANAGER TO COMPLETE)

I/WE OPERATE IN ACCORDANCE WITH THE FAIR HOUSING LAW, I/WE DO NOT DISCRIMINATE AGAINST ANY PERSON IN THE TERMS, CONDITIONS OR PRIVILEGES OF SALE OR RENTAL OF A DWELLING OR IN THE PROVISIONS OF SERVICES OF FACILITIES IN CONNECTION THEREWITH, BECAUSE OF RACE, COLOR, SEX, RELIGION, HANDICAP, FAMILIAL STATUS OR NATIONAL ORIGIN.

J.B. MILAM APARTMENTS DOES NOT DISCRIMINATE ON THE BASIS OF HANDICAPPED STATUS IN THE ADMISSION OR ACCESS TO, OR TREATMENT OR EMPLOYMENT IN, ITS FEDERALLY ASSISTED PROGRAMS AND ACTIVITIES.

THE PERSON NAMED BELOW HAS BEEN DESIGNATED TO COORDINATE COMPLIANCE WITH NON-DISCRIMINATION REQUIREMENTS CONTAINED IN THE DEVELOPMENT OR HOUSING AND URBAN DEVELOPMENTS REGULATING IMPLEMENTING SECTION 504. (24 CFR PART 8 DATED JUNE 2, 1988).

CATHY HAYNES
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TO WHOM IT MAY CONCERN:

I/WE AUTHORIZE THE MANAGEMENT AGENT TO INVESTIGATE MY/OUR CREDIT AND VERIFY ALL INFORMATION AND REFERENCES GIVEN. THE INFORMATION OBTAINED WILL BE USED FOR MANAGEMENT PURPOSES ONLY AND WILL BE HELD IN CONFIDENCE.

I/WE CERTIFY THAT ALL APPLICATION INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE ALSO CERTIFY THAT THE HOUSING I/WE WILL OCCUPY WILL BE MY/OUR PERMANENT RESIDENTCE. I/WE FURTHER CERTIFY THAT I/WE WILL NOT MAINTAIN A SEPARATE SUBSIDIZED RENTAL UNIT IN A DIFFERENT LOCATION.

CREDIT APPROVAL: _____ APPROVED _____ DISAPPROVED (ATTACH COPY OF CREDIT REPORT)

IF DISAPPROVED, STATE REASON: _____

PERFORMED BY: _____ DATE: _____

CRIMINAL BACKGROUND CHECK VERIFIED? _____ YES _____ NO

CONTACT: _____ DATE: _____

EMPLOYMENT VERIFIED? _____ YES _____ NO

CONTACT: _____ DATE: _____

SPOUSE EMPLOYMENT VERIFICATION? _____ YES _____ NO

CONTACT: _____ DATE: _____

FORMER RESIDENCY VERIFICATION? _____ YES _____ NO

CONTACT: _____ DATE: _____

FORMER RESIDENCY VERIFICATION? _____ YES _____ NO

CONTACT: _____ DATE: _____

COMMENTS: _____

