DEL RIO
ROTARY CLUB

EQUAL HOUSING OPPORTUNITY

PRE-APPLICATION

DATE: _____ TIME: _____ PHYSICALLY HANDICAPPED: _____

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ SPOUSE'S SOCIAL SECURITY #: _____

STATUS: ( ) U.S. CITIZEN ( ) RESIDENT ALIEN

MARITIAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPARATED

TWO NAMES AND PHONE NUMBERS OF FRIENDS/RELATIVES WE CAN CONTACT

NAME: _____ TELEPHONE: _____

NAME: _____ TELEPHONE: _____

PRESENT MONTHLY RENT: _____ NUMBER OF BEDROOMS: _____

NUMBER OF PERSONS IN HOUSEHOLD: _____

NAME AND PHONE NUMBER OF PRESENT LANDLORD: _____

LIST ALL PERSONS INCLUDING YOURSELF WHO WILL LIVE IN THIS RENTAL UNIT WHILE YOU ARE ON THIS PROGRAM. (LIST ALL PERSONS, HEAD OF HOUSEHOLD FIRST.)

FULL NAME BIRTHDATE AGE SEX

1.) _____ _____ _____ _____

OCCUPATION: _____ RELATIONSHIP: _____

2.) _____ _____ _____ _____

OCCUPATION: _____ RELATIONSHIP: _____

INCOME INFORMATION: LIST FULL AND/OR PART TIME EMPLOYMENT, SOCIAL SECURITY BENEFITS, SUPPLEMENTAL SECURITY INCOME (SSI), PENSION, AND ANY OTHER SOURCE OF INCOME.

HOUSEHOLD MEMBER: NAME AND ADDRESS OF EMPLOYER: CURRENT: ANTICIPATED:

1) _____ _____ _____ _____

2) _____ _____ _____ _____

CHECKBOOK ACCOUNT: BANK _____ ACCOUNT # _____ AMOUNT: _____

PASSBOOK SAVINGS: BANK _____ ACCOUNT # _____ AMOUNT: _____

SAVINGS CERTIFICATE: BANK _____ ACCOUNT # _____ AMOUNT: _____

AUTOMOBILE(S)

MAKE:	MODEL:	YEAR:	LICENSE PLATE NUMBER:	DRIVER'S LICENSE NUMBER:
MAKE:	MODEL:	YEAR:	LICENSE PLATE NUMBER:	DRIVER'S LICENSE NUMBER:

MEDICAL & UNUSUAL EXPENSES:

ARE YOU RECEIVING MEDICAL BENEFITS? _____

ARE YOU RECEIVING MEDICAL ASSISTANCE THROUGH WELFARE DEPARTMENT? _____

DO YOU PAY FOR ANY MEDICAL/INSURANCE/HOSPITALIZATION (SUCH AS BLUE CROSS, ETC)
IF PAID DIRECTLY BY YOU, INDICATE AMOUNT OF PREMIUM AND HOW OFTEN PAID. _____

ARE YOU MAKING PAYMENT ON ANY OUTSTANDING MEDICAL BILLS? _____

DO YOU TAKE PRESCRIPTION DRUGS ON A REGULAR BASIS? _____

DO YOU ANTICIPATE ANY HEALTH CARE RELATED EXPENSES FOR THE NEXT 12 MONTHS WHICH ARE NOT COVERED BY HEALTH INSURANCE? _____

EXPLAIN:

_____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? _____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

NAME:	ADDRESS:	RELATIONSHIP:	PHONE NUMBER:

NOTE:

(1) AFTER FORMAL PROCESSING OF THIS APPLICATION HAS BEGUN, THE INFORMATION REPORTED AND VERIFIED WILL HAVE TO BE UPDATED EVERY 6 MONTHS INORDER TO REMAIN ON THE WAITING LIST.
(2) A CREDIT REPORT MAYBE OBTAINED PRIOR TO INITIAL OCCUPANCY.
(3) A POLICE CHECK AND CREDIT BUREAU CHECK MAY BE COMPLETED.
(4) COPIES OF BIRTH CERTIFICATES OR OTHER PROOF OF AGE WILL BE REQUIRED ON ALL HOUSEHOLD MEMBERS PRIOR TO INITIAL OCCUPANCY.

I/WE THE APPLICANT(S) AGREE TO GIVE THE MANAGEMENT/OWNER THE AUTHORITY TO INVESTIGATE MY/OUI CREDIT RATINGS, MY/OUR CURRENT AND PAST RENTAL RECORD, AND ALL OTHER INFORMATION NECESSARY T(DETERMINE ELIGIBILITY. I/WE UNDERSTAND THAT ANY MISREPRESENTATION OF INFORMATION ON THIS FORM WILL DISQUALIFY ME FROM CONSIDERATION FOR LEASING AND MAY BE GROUND FOR EVICTION.

I HEREBY AFFIRM THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDG

_____ _____
(SIGNATURE OF HEAD OF HOUSEHOLD) (DATE)

_____ _____
(SIGNATURE OF HEAD OF HOUSEHOLD) (DATE)

_____ _____
(SIGNATURE OF INTERVIEWER) (DATE)