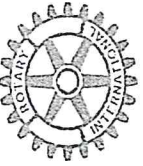


DEL RIO
ROTARY CLUB



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

MARITAL 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 IN ORDER 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/OUR CREDIT RATINGS, MY/OUR CURRENT AND PAST RENTAL RECORD, AND ALL OTHER INFORMATION NECESSARY TO 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 KNOWLEDGE

(SIGNATURE OF HEAD OF HOUSEHOLD) _____ (DATE)

(SIGNATURE OF HEAD OF HOUSEHOLD) _____ (DATE)

(SIGNATURE OF INTERVIEWER) _____ (DATE)