



Good Shepherd Community

APPLICATION FOR HOUSING

(Residential Care Facility)

This is a housing application for: **Roberts Building**
2801 Aldersgate Road
Little Rock, AR 72205

Please complete this application and return to: Roberts Building
Attn: Manager
2801 Aldersgate Road
Little Rock, AR 72205

Occupants in this building must be 62 years or older or fall in the exception category of disabled by definition. Applications are placed in order of date and time received. An applicant may be interviewed only after the receipt of this tenant application.

Please Print Clearly

1) GENERAL INFORMATION:

Applicant Name(s): _____

Address: _____
Street Apt# City State Zip

Daytime Phone: _____ Evening Phone: _____

Email Address: _____

No. of BR's in Current Unit: _____ Do You: Rent Own (check one)

Amount of current monthly rental or mortgage payment: \$ _____

If owned, do you receive monthly rental income from the property? Yes No (check one)

Check utilities paid by you: Electric Gas Water Other (Specify: _____)

Approximate monthly cost of utilities paid by you (excluding phone and cable TV): \$ _____

How did you hear about us? _____

Bedroom Size Requested: 1 Bedroom 2 Bedrooms Accessible

Any Special Needs: _____

2) HOUSEHOLD COMPOSITION:

	Name	Relationship to head	Birth Date	Age (Optional)	Social Security #	Student (Y/N)
Head						
Co-T						

3) HEALTH INFORMATION:

Are you currently under the care of a physician? Yes No

If yes, list details: _____

List all the medications you are currently taking:

Name	Dosage	Frequency

Please indicate any of the following that apply:

Hearing Loss	Hearing Aids	Sight Impairment	
Dentures	Eyeglasses	Mobility Issues	
Use Cane	Use Walker	Use Wheelchair	
Mobile Scooter	Smoker	Drink Alcohol	
Use Oxygen	Colostomy	Ileostomy	

Can you take and manage medication without assistance? Yes No

Do you have any medication or food allergies? Yes No

If yes, please list: _____

Do you require any special dietary controls? Yes No

If yes, please specify: _____

Please explain any needs that may affect your ability to live independently: _____

Please list all the physicians who currently care for you:

Name:		
Street Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Specialty:		

Name:		
Street Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Specialty:		

Name:		
Street Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Specialty:		

Is any student a person who was previously under the care and placement of a foster care program (under Part B or E of Title IV of the Social Security Act)? Yes No

Does anyone have your Power of Attorney? Yes No

If yes list names, address and phone number: _____

4) ADDITIONAL INFORMATION:

Are you or any member of your family currently using an illegal substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or any member of your family ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

Are you or any member of your family subject to a lifetime sex offender registration Requirement in any state?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

Have you or any member of your family ever been evicted from any housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

5) REFERENCE INFORMATION:

Current Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	
Prior Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	
Personal Reference #1:		
Address:		
Relationship:		Phone #:
Personal Reference #2:		
Address:		
Relationship:		Phone #:

In Case of Emergency Notify:		
Address:		
Relationship:		Phone #:

In Case of Emergency Notify:		
Address:		
Relationship:		Phone #:

In Case of Emergency Notify:		
Address:		
Relationship:		Phone #:

6) VEHICLE INFORMATION (If applicable):

List any cars, trucks, or other vehicles owned. Parking will be provided for one vehicle. Arrangements with Management will be necessary for more than one vehicle.

Type of Vehicle:	License Plate #:
Year/ Make:	Color:

7) CERTIFICATION:

I/We hereby certify that I/We, Will Not maintain a separate subsidized rental unit in another location. I/We further certify that this will be my/our permanent residence. I/We understand I/We must pay a security deposit for this apartment prior to occupancy. I/We understand that my eligibility for housing will be based on applicable income limits and by Managements selection criteria. I/We certify that all information in this application is true to the best of my/our knowledge and I/We understand that false statements or information are punishable by law and will lead to cancellation of this applicable or termination of tenancy after occupancy. All adult applicants. 18 or older, must sign application.

SIGNATURE(S):

Signature of Applicant

Date

Signature of Co-Applicant

Date

GOOD SHEPHERD USE ONLY:
Date Received: _____ By: _____
Additional Information Needed: Yes ___ No ___ (Specify: _____)
Date Contacted/Response: _____

