



CENTRAL FALLS HOUSING AUTHORITY

30 Washington Street

Central Falls, RI 02863

Main Office (401) 648-8298 TDD 800-545-1833 Ext. 404

To Whom It May Concern:

Thank you for your interest in the Central Falls Housing Authority. Attached you will find an application for Public Housing. The following paperwork that is **REQUIRED** to be attached to the application is:

- **Copy of a Valid Driver's License / Photo ID or Passport**
- **Copy of Birth Certificate**
- **Copy of Social Security Card**
- **Verification of all income (Ex. Copies of Pay Stub, bank statements, Social Security and SSI award letter, etc.)**

IMPORTANT: Please make sure that all areas of the application are filled in and completed and any **required** additional paperwork is attached prior to submission. If you have any questions, please call the Public Housing Manager at the number provided above. Applications can be dropped off and put in our drop box which is located in the hallway of our office.



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For Office Use:
 Date: _____
 App. # _____
 BR. Size _____
 Preference _____

Public Housing Rental Application

The Central Falls Housing Authority has two elderly, disabled, handicapped high-rises Public Housing developments. Please select from the options below as to which development you would like to apply for:

| WAITLIST OPTIONS | | |
|-----------------------|--|----------------------|
| DEVELOPMENT SELECTION | NAME | ADDRESS |
| | Forand Manor Development Wait List | 30 Washington Street |
| | Wilfrid Manor Development Wait List | 466 Hunt Street |
| | Forand Manor and Wilfrid Manor Wait List | |

The below Public Housing Application must be completed in full. If assistance is needed, please contact the Authority to schedule an appointment. If you are in need of a translator, please notify the office 48 hours in advance of your appointment so arrangements can be made.

| APPLICANT INFORMATION | | | |
|---|--------------------------|--|--|
| Head of Household Name: | | | |
| Date of Birth: | SSN: | Phone: | |
| Current address: | | | |
| City: | State: | Zip Code: | |
| Own Rent (Please Circle) | Monthly payment or rent: | How Long? | |
| Marital Status: Unmarried (Single, Widowed, Divorced) | | Married (Please Circle) | |
| Maiden Name: | | If Divorced or separated; name of former spouse: | |
| Race: White Black American Indian/Alaskan Native Asian/Pacific Islander Other | (Please Circle) | | |
| Ethnicity: Hispanic Not Hispanic | (Please Circle) | | |
| The above information pertaining to race and ethnicity is required for statistical purposes so that HUD may determine the degree to which its programs are utilized by minority families. | | | |

| FAMILY COMPOSITION: List all persons, including yourself, who will live in the unit. (Lead applicant is head of household) | | | | | | | | |
|--|-----------|--------------|-----|------|----------------|---------------|-----|-------------------|
| | FULL NAME | RELATIONSHIP | SEX | RACE | PLACE OF BIRTH | DATE OF BIRTH | AGE | SOCIAL SECURITY # |
| 1 | | Self (HOH) | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |

| INCOME SOURCES | | | | |
|---------------------------------------|-------------------|-------------------|-------------------|-------------------|
| List all monthly income amounts below | | | | |
| SOURCE OF INCOME | FAMILY MEMBER # 1 | FAMILY MEMBER # 2 | FAMILY MEMBER # 3 | FAMILY MEMBER # 4 |
| Social Security | | | | |
| SSI | | | | |
| GPA | | | | |
| Veterans Benefits | | | | |
| Pension | | | | |
| Worker's Compensation | | | | |
| Alimony | | | | |
| AFDC / TANF | | | | |
| Employment | | | | |
| Unemployment | | | | |
| SSDI | | | | |
| Other (Please describe below) | | | | |
| | | | | |

| ASSET INFORMATION | | | | | | |
|--------------------------|------------------------|------------------------|------------------------|------------------------|---------------|-----------|
| SOURCE OF INCOME | FAMILY MEMBER #1 VALUE | FAMILY MEMBER #2 VALUE | FAMILY MEMBER #2 VALUE | FAMILY MEMBER #3 VALUE | INTEREST RATE | ACCOUNT # |
| Checking | | | | | | |
| Checking | | | | | | |
| Savings | | | | | | |
| Savings | | | | | | |
| Savings | | | | | | |
| Certificates of Deposit | | | | | | |
| Certificates of Deposit | | | | | | |
| IRA | | | | | | |
| Annuities | | | | | | |
| Life Insurance-Whole | | | | | | |
| Life Insurance-Term | | | | | | |
| Other (list) | | | | | | |
| Other (list) | | | | | | |
| Other (list) | | | | | | |

| PLEASE COMPLETE THE FOLLOWING QUESTIONS | | | |
|--|-----|----|------------------------|
| Are you an owner/co-owner of property (in the U.S. or other country)? | Yes | No | (Please Circle) |
| If yes, list type of property, value and location: | | | |
| Have you disposed of any assets at less than market value in the last two years? | Yes | No | (Please Circle) |
| If yes, please explain: | | | |

| MEDICAL EXPENSES (Elderly/Disabled/Handicapped Applicants Only) | |
|--|--|
| Please check all that apply to your household: | |
| <input type="checkbox"/> | Pay any portion of your medical premiums or hospitalization coverage |
| <input type="checkbox"/> | Pay any co-payments for doctors or hospital |
| <input type="checkbox"/> | Pay for prescriptions |

| | |
|--|---|
| | Pay for non-prescription medicines that your doctor has ordered |
| | Any other medical expenses, if yes, describe below |
| | |

HANDICAPPED/DISABLED ASSISTANCE INFORMATION

Please check all that apply to your household

| | |
|--|---|
| | Have non-reimbursed expenses anticipated during the next 12 months for attendant care and auxiliary apparatus for a family member with a disability or handicap that are necessary to enable a family member (including the person with the handicap or disability) to be employed? |
| | Any member of your household require special housing facilities? If yes, please explain below: |
| | |

PROGRAM INFORMATION

Please circle if the below applies to your household and where applicable describe the specifics

| | | | |
|--|-----|----|------------------------|
| Are you currently a participant receiving assistance in any HUD Program? Example: Section 8 or Public Housing | Yes | No | (Please Circle) |
| If yes, what Housing Authority is the assistance affiliated with? | | | |

HEAD OF HOUSEHOLD AND FAMILY BACKGROUND INFORMATION

| | | | |
|--|--------------|---------|------------------------|
| Have you ever been convicted of a felony? | Yes | No | (Please Circle) |
| If yes, when, for what and where? | Date(s) | Reason: | Where: |
| Have any of your family members been convicted of a felony? | Yes | No | (Please Circle) |
| If yes, when, for what and where? | Date(s) | Reason: | Where: |
| Have you or any family members been arrested and/or convicted of any crimes? | Yes | No | (Please Circle) |
| If yes, when, for what and where? | Date(s) | Reason: | Where: |
| Have you ever lived in any state other than Rhode Island? | Yes | No | (Please Circle) |
| If yes, where? | City | State | |
| Have you ever lived in Public Housing? | Yes | No | (Please Circle) |
| If yes, where? | City | State | |
| Have you ever received Section 8 or any other HUD program assistance? | Yes | No | (Please Circle) |
| If yes, what program and where? | Program: | City: | State: |
| Do you owe back rent to any of the above or to the CFHA? | Yes | No | (Please Circle) |
| If yes, where? | City | State | |
| Have you ever been evicted or violated your lease while participating in a Public Housing, Section 8, other HUD Program? | Yes | No | (Please Circle) |
| If yes, what program and where and why? | What Program | City | State |
| Explain reason | | | |
| Are you or anyone in your household required to register on any state's life time sex offender registry? | Yes | No | (Please Circle) |
| Are you or anyone in your household a medical marijuana user? | Yes | No | (Please Circle) |
| If yes, list all States that you or any other member of you household has ever lived in: | | | |
| | | | |

EMERGENCY CONTACTS – Please provide two numbers of friends/relatives that we may contact if we are unable to reach you.

| | | |
|-------|--------|---------------|
| Name: | Phone: | Relationship: |
| Name: | Phone: | Relationship: |

| LANDLORD HISTORY | |
|---|----------------------|
| Present monthly rent | \$ |
| How much do you pay for utilities per month? | \$ |
| Current address | Street: City: State: |
| Current landlord name | Name: |
| Current landlord phone number | Home: Cell: |
| Current landlord address | Street: City: State: |
| How long have you lived at this current address? | Months: Years: |
| Previous address | Street: City: State: |
| Previous landlord name | Name: |
| Previous landlord address | Street: City: State: |
| How long have you lived at this address? | Months: Years: |
| If there is less than 5 years of landlord history, please attach additional information of previous landlords and rental history. | |

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the U.S. as to any matter within its jurisdictions.

HEAD OF HOUSEHOLD'S INITIALS _____

I understand that I must notify the Central Falls Housing Authority, in writing, of any change of address. Failure to do so will result in the removal of your name from the waiting list.

HEAD OF HOUSEHOLD'S INITIALS _____

I attest the above information to be true and accurate to the best of my knowledge.

Applicant's Signature _____
Date

CFHA Representative Signature _____
Date