

**ADIRONDACK COMMUNITY HOUSING TRUST
PROGRAM APPLICATION**

www.adkhousing.org

518.873.6888

HOUSEHOLD INFORMATION

APPLICANT NAME: _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

CO-APPLICANT NAME: _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

STREET ADDRESS: _____ **TOWN:** _____ **ZIP CODE:** _____

MAILING ADDRESS: _____ **TOWN:** _____ **ZIP CODE:** _____

HOME/MOBILE #: _____ **WORK #:** _____

EMAIL ADDRESS: _____

NUMBER OF DEPENDENTS UNDER 18 YEARS OF AGE: _____

TOTAL NUMBER OF PERSONS IN HOUSEHOLD: _____

TOTAL ANNUAL HOUSEHOLD INCOME (GROSS): _____

MONTHLY HOUSING EXPENSE:

RENT: _____ **HEAT:** _____ **ELECTRIC:** _____

EMPLOYMENT INFORMATION

APPLICANT'S EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

MONTHS/YEARS AT THIS EMPLOYER: _____ **YEARS/** _____ **MONTHS**

CO-APPLICANT EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

MONTHS/YEARS AT THIS EMPLOYER: _____ **YEARS/** _____ **MONTHS**

HOME PURCHASE INFORMATION

ARE YOU A FIRST TIME HOME BUYER: YES NO

IN NOT, EXPLAIN: _____

DO YOU HAVE A SPECIFIC HOME YOU ARE INTERESTED IN PURCHASING, IF SO WHERE IS IT
LOCATED: _____

DO YOU HAVE A SPECIFIC COMMUNITY THAT YOU WOULD LIKE TO PURCHASE A HOME IN:

DO YOU KNOW OF ANY PROBLEMS WITH YOUR CREDIT RATING: YES NO

IF YES, EXPLAIN: _____

HAVE YOU BEEN PRE-QUALIFIED BY A BANK: YES NO

IF YES, FROM WHAT BANK: _____ PRE-QUALIFIED AMOUNT: _____

HAVE YOU APPLIED FOR A HOME LOAN IN THE PAST: YES NO

WERE YOU DENIED A HOME LOAN: YES NO

DO YOU HAVE EXCESSIVE MEDICAL BILLS: YES NO

IF YES, MONTHLY PAYMENT AMOUNT: _____

OTHER INFORMATION: _____

** please continue to the voluntary information monitoring document on the next page **

VOLUNTARY INFORMATION FOR MONITORING PURPOSES

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against applicants on the basis of race, national origin, and sex. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way.

RACE/NATIONAL ORIGIN:

- White
- Black
- Hispanic
- Asian or Pacific Islander
- Native American or Alaskan Native

SEX OF APPLICANT: Male Female

SEX OF CO-APPLICANT: Male Female

MARITAL STATUS:

- Married
- Separated
- Unmarried (single, divorced or widowed)

HANDICAPPED: Yes No

TYPE OF HOUSEHOLD:

- Single, non-elderly
- Elderly
- Related/Single Parent
- Related/Two Parent
- Other

I, THE UNDERSIGNED, HEREBY CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. The Adirondack Community Housing Trust is hereby authorized to perform such verifications of this information as may be necessary.

I HEREBY CONSENT TO THE RELEASE OF CREDIT INFORMATION that may be available from a credit reporting agency. Such information will be delivered directly to the Adirondack Community Housing Trust.

Applicant's Signature

Date

Co-Applicant's Signature

Date

PLEASE RETURN THIS APPLICATION FORM TO:

By Mail:
Adirondack Community Housing Trust
P.O. Box 157
Elizabethtown, NY 12932

By Email:
Emily@adkhousing.org

By Fax:
518.873.9102