

**APPLICATION FOR ADMISSION  
AND RENTAL ASSISTANCE**

**DIAMOND HEIGHTS APARTMENTS**

APPLICANT NAME \_\_\_\_\_ APPLICATION NUMBER \_\_\_\_\_  
 CURRENT ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**HOUSEHOLD COMPOSITION AND CHARACTERISTICS**

1. Starting on the first line, list the Head of Household and all other members who will be living in the unit. Give the Relations of each family member to the head.

MEMBER'S FULL NAME	RELATIONSHIP	BIRTHDATE	AGE	SEX	SOC SEC #

2. Race of Head of Household (check one) {For statistical purposes only}  
 \_\_\_\_\_ White    \_\_\_\_\_ Black    \_\_\_\_\_ American Indian/Alaskan Native    \_\_\_\_\_ Asian/Pacific Islander
3. Ethnicity of Head of Household {For statistical purposes only}  
 \_\_\_\_\_ Hispanic    \_\_\_\_\_ Non-Hispanic
4. Have you or any member of your household been evicted from Public Housing, Indian housing, Section 23 housing or housing assisted by the Section 8 program, for drug-related criminal activity during the past three years?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 If yes, please explain: \_\_\_\_\_
5. Do you or any member of your household have a history of engaging in the use of a controlled substance or in alcohol abuse that has not been abated through a supervised rehabilitation program or other means of rehabilitation?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 If yes, please explain: \_\_\_\_\_
6. Are you or any member or your household subject to a lifetime state sex offender registration program in any state?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 If yes, please explain: \_\_\_\_\_
7. Have you or any member of your household ever been convicted of a misdemeanor or felony?  
 \_\_\_\_\_ Yes    \_\_\_\_\_ No  
 If yes, please explain: \_\_\_\_\_
8. Please identify any special housing needs your household has: \_\_\_\_\_

**\*\* If you have a disability and need a reasonable accommodation in order to participate in the application process or to make effective use of the housing program, you have the right to request such an accommodation.**



9. Are there any live-in care attendants who are part of the household? \_\_\_\_\_ Yes \_\_\_\_\_ No
10. Do you have or have you ever experienced bed bugs? \_\_\_\_\_ Yes \_\_\_\_\_ No
11. Do you own a pet? \_\_\_\_\_ Yes \_\_\_\_\_ No Cat, Dog, or Bird? \_\_\_\_\_

**PREVIOUS RENTAL HISTORY**

(Five years of rental history will be verified. If unable to list all references in the spaces provided below, please document additional references on a separate sheet of paper and attach to application.)

Name and Address of your Present Landlord

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_  
How long have you lived there? \_\_\_\_\_  
Reason for leaving. \_\_\_\_\_

Name and address of your Former landlord:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_  
How long had you lived there? \_\_\_\_\_  
Reason for leaving. \_\_\_\_\_

Name and address of your Former landlord:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_  
How long had you lived there? \_\_\_\_\_  
Reason for leaving. \_\_\_\_\_

**PROFESSIONAL REFERENCE HISTORY**

(If five years of rental history cannot be provided, please list 3 professional references in the space provided below. A professional reference is not a relative or friend. Examples of a professional reference are: clergyman, doctors, employers, etc.)

Name and Address of professional reference

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Telephone No. \_\_\_\_\_  
Work Telephone No. \_\_\_\_\_

Name and Address of professional reference

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Telephone No. \_\_\_\_\_  
Work Telephone No. \_\_\_\_\_

Name and Address of professional reference

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Telephone No. \_\_\_\_\_  
Work Telephone No. \_\_\_\_\_

**ASSETS INFORMATION**

1. Please list all checking and savings accounts; certificates of deposits and other bank account. Stock and bond accounts should also be listed as well as annuity, trust, IRA, 401K accounts. Also include any cash values associated with whole life insurance policies.

<u>Family Member First Name</u>	<u>Type of Account</u>	<u>Account Number</u>	<u>Current Balance</u>	<u>Name &amp; Address where Value can be Verified</u>
_____	1 _____	_____	\$ _____	Name _____
	2 _____	_____	\$ _____	Address _____
	3 _____	_____	\$ _____	City _____ State _____ ZIP _____
_____	1 _____	_____	\$ _____	Name _____
	2 _____	_____	\$ _____	Address _____
	3 _____	_____	\$ _____	City _____ State _____ ZIP _____
_____	1 _____	_____	\$ _____	Name _____
	2 _____	_____	\$ _____	Address _____
	3 _____	_____	\$ _____	City _____ State _____ ZIP _____
_____	1 _____	_____	\$ _____	Name _____
	2 _____	_____	\$ _____	Address _____
	3 _____	_____	\$ _____	City _____ State _____ ZIP _____

2. Are any of the above-mentioned assets held jointly? If yes, show both names in family member column.  
 Yes \_\_\_\_\_ No \_\_\_\_\_

3. During the past 2 years, have you sold, for less than fair market value, or given away any real property or other assets (including cash) valued at more than \$1,000? If yes, please list Market Value of this property:  
 Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

4. Do you own your own home? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 \_\_\_\_\_ Paid \_\_\_\_\_ Mortgaged

If, mortgaged, with whom? \_\_\_\_\_

If the location of your home is different than the address listed on this application, please list the address.

\_\_\_\_\_  
 \_\_\_\_\_

5. Do you own other property/properties? Please list. Yes \_\_\_\_\_ No \_\_\_\_\_

Street \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**EMPLOYMENT HISTORY**

Name and Address of Head's Present Employer:

\_\_\_\_\_  
 \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
 \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_  
 \_\_\_\_\_ How Long Have You Worked There: \_\_\_\_\_

Name and Address of Spouse's or Co-Head's Employer:

\_\_\_\_\_  
 \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
 \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_  
 \_\_\_\_\_ How Long Have You Worked There: \_\_\_\_\_

**INCOME INFORMATION**

Did you file a Federal Income Tax Return last year? Yes \_\_\_\_\_ No \_\_\_\_\_

Does anyone living outside your household pay any of your bills? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list gross payments (before taxes) made to each family member age 18 or older for social security, SSI, disability, wages, worker's compensation, welfare assistance, unemployment benefits, retirement payments, alimony, military pay, periodic gifts, barter income, and business or professional income.

<u>Family Member</u> <u>First Name</u>	<u>Gross</u> <u>Payment</u>	<u>Employer or other Source where reported income can be verified.</u>
_____	\$ _____	Name _____ Address _____ City _____ State _____ Zip _____
_____	\$ _____	Name _____ Address _____ City _____ State _____ Zip _____
_____	\$ _____	Name _____ Address _____ City _____ State _____ Zip _____
_____	\$ _____	Name _____ Address _____ City _____ State _____ Zip _____
_____	\$ _____	Name _____ Address _____ City _____ State _____ Zip _____

Attach additional sheets if necessary.

**ALLOWABLE MEDICAL EXPENSES** (Paid out-of-pocket for the last 12 months.)

If you wish to claim an allowance for 1) Medicare and/or other supplemental health insurance premiums; 2) medical, dental, or optical expenses; or 3) prescription or over-the-counter drug expenses, please provide the first name of family member claiming the expense and name and address of the provider of the service or product.

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

Family Member First Name \_\_\_\_\_  
Expense Claimed \$ \_\_\_\_\_  
Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_

I would like to request a copy of the Owner/Management Agents Resident Tenant Selection Criteria.  
Yes \_\_\_\_\_ No \_\_\_\_\_

**APPLICANT CERTIFICATION**

I certify that if selected to receive assistance, the unit I occupy will be my only residence. I understand that the above information is being collected to determine my eligibility. I certify that the statements made in this application are true and complete to the best of my knowledge and belief. I understand that I can be fined up to \$10,000 or imprisoned up to five years if I furnish false or incomplete information.

Signature of Head \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse/Co-Head \_\_\_\_\_ Date: \_\_\_\_\_

=====
PLEASE RETURN COMPLETED APPLICATION TO:
SIOUXLAND AGING SERVICES, INC.; ATTN: HOUSING DEPARTMENT;
2301 PIERCE STREET; SIOUX CITY, IA 51104

## AUTHORIZATION TO RELEASE INFORMATION

Re: \_\_\_\_\_ (Please complete landlord's address)  
\_\_\_\_\_  
\_\_\_\_\_

To Whom It May Concern:

I authorize any person, agency, or institution to supply information requested by Siouxland Aging Services, Inc. concerning me, or other members of my household. This information will be used to determine my eligibility for housing. The information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD.) HUD requires the housing owner to verify all information.

**You do not have to sign the form if either the requesting organization or the organization supplying the information is left blank.**

Signature: \_\_\_\_\_  
(Head of Household)  
Social Security Number \_\_\_\_\_

Signature: \_\_\_\_\_  
(Co-tenant or Co-applicant)  
Social Security Number \_\_\_\_\_

Date: \_\_\_\_\_

-----  
**Penalties For Misusing This Consent:**

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government, HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief as may be appropriate, against the officer or employee of HUD, the PHA or owner responsible for the authorized disclosure or improper use. Siouxland Aging Services, Inc. does not discriminate on the basis of handicapped status in the admission or access to or treatment of employment in, its federally assisted programs and activities.

## ACKNOWLEDGEMENT

**Credit/Criminal – Landlord Verification**

The applicant agrees and acknowledges that a credit/criminal and landlord verification will be completed. Any information given shall be held in strict confidence.

Applicant's  
Signature: \_\_\_\_\_

Name/  
Address  
(printed) \_\_\_\_\_  
\_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Date \_\_\_\_\_

Siouxland Aging Services, Inc. does not discriminate based upon race, color, creed, religion, sex, nation origin, age, familial status, or handicap.

Apartment \_\_\_\_\_

**SIUXLAND AGING SERVICES, INC.**

Revised 9/29/11 lk

**2301 Pierce Street, Sioux City, IA 51104**

TO: All Tenants and Applicants

FROM: Siouxland Aging Services, Inc.

RE: Reasonable Accommodations  
For Applicants/Residents with Disabilities

Please be advised that persons who apply for residency or are current residents are entitled to request reasonable accommodations.

The definition of reasonable accommodation is a change in policy or procedure to accommodate an applicant or resident with disabilities which does not constitute either undue burdens or a fundamental alteration of the housing program.

Reasonable accommodations vary greatly depending on the individual and can be a physical accommodation or a change in policy.

For more information, contact:

Siouxland Aging Services, Inc.  
2301 Pierce Street  
Sioux City, IA 51104

Phone: (712) 279-6900  
Or 1-800-798-6916