

CMHI Property Management, Inc.
*Calais Methodist Home, Inc. * Highpoint Apartments * Waterview Terrace*
Housing for the Elderly and/or Disabled
116 Palmer St., Calais, ME 04619
(207) 454-7196 Phone * (207) 454-2499 Fax
chelsie@cmhihome.org

RENTAL APPLICATION

NAME _____

I would like to apply to (check all that apply)

___ Calais Methodist Home, Inc.

___ Highpoint Apartments (Academy St. Calais)

___ Waterview Terrace (Barren St. Eastport)

This application is the first step in seeking to rent an apartment at CMHI Property Mngt., Inc. in Calais, ME. Due to Federal legislation, extensive information is required by Rural Development to assure the government that housing which they subsidize is used fairly and to maximum efficiency.

IMPORTANT:

Please be sure to fill out all information with complete addresses, and phone numbers where applicable.

Also be sure to sign and date certification and authorization lines. If a section does not apply to your situation, please enter N/A or 0 in the space provided.

Applications will only be accepted after they have been completely filled out.

Thank you for your interest in renting from Calais Methodist Home, Inc.

In accordance with Federal law and U.S. Department of Agriculture policy, Calais Methodist Home, Inc is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs).
To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250 or call (800) 795-3272 (voice), or (202) 720-6382 (TDD).



Are you without, or about to be without housing? yes no

Is anyone in the household a smoker? Yes No

INCOME

List **ALL** sources of income for all members of household as requested below.

Examples of sources of income include but are not restricted to:

Social Security, SSI Benefits, Pension, Veteran's Benefits, Employment, Worker's Comp, Unemployment, Alimony, Child Support, Interest Income, Rental Income, Other Income.

Then, please fill in the name of the Household Member, the income source, its address, and monthly income amounts in spaces provided below.

Source _____

Address _____

Monthly Income \$ _____

Household Member _____

Source _____

Address _____

Monthly Income \$ _____

Household Member _____

Source _____

Address _____

Monthly Income \$ _____

Household Member _____

Source _____

Address _____

Monthly Income \$ _____

Household Member _____

Source _____

Address _____

Monthly Income \$ _____

Source _____

Address _____

Monthly Income \$ _____

Household Member _____

Household Member _____

If additional space is needed, please attach a separate piece of paper

ASSETS FOR ALL HOUSEHOLD MEMBERS

Checking/Savings

Bank Name _____

Address _____

Balance \$ _____

Checking/Savings

Bank Name _____

Address _____

Balance \$ _____

CD's

Bank Name _____

Address _____

Balance \$ _____

CD's

Bank Name _____

Address _____

Balance \$ _____

Stocks, Bonds, Mutual Funds

Name of Broker or Fund _____

Address _____

Value of:

Stocks \$ _____

Bonds \$ _____

Real Property

Do you own any property? yes no If YES, please provide a copy of your tax bill.

Type and location of property _____

Does your property produce income yes no

Monthly amount of income \$ _____

Mortgage Balance \$ _____

Amount of Annual Homeowners Insurance Premium \$ _____

Is your property for sale yes no

Have you sold/disposed of any property in the past two years? yes no

If yes, type of property _____ Value when sold/disposed \$ _____

Amount sold/disposed for \$ _____ Date of transaction _____

MEDICAL / HANDICAP ASSISTANCE EXPENSE

Does the Applicant or Co-Applicant qualify to receive the \$400 Elderly deduction?

(must be 62 years or older / or handicapped / or disabled) yes no

MEDICAL EXPENSES

Medicare-----Monthly Amount \$ _____ Deductible (if any) \$ _____

Name of Health Insurance Company _____

Monthly Amount \$ _____ Deductible (if any) \$ _____

Projected Medical Costs **NOT COVERED** by insurance \$ _____

Medical Bills / Costs for which you are making Monthly Payments:

Payable to _____

Balance Due \$ _____ Monthly payment \$ _____

Anticipated Drug / Prescription Costs **NOT COVERED** by insurance \$ _____

Pharmacy _____

Anticipated Over the Counter, Medically necessary items (aspirin, stomach remedies, hearing aid batteries, oxygen) and the cost of medical related travel. Receipts must be submitted for all expenses.

LANDLORD REFERENCES

CURRENT LANDLORD

Name _____

Address _____

Phone # _____

Monthly Rent Amount \$ _____ Date Moved In _____

Reason for Moving _____

PRIOR LANDLORD

Name _____

Address _____

Phone # _____

Monthly Rent Amount \$ _____ Date Moved In _____

Date Moved Out _____

Reason for Moving _____

CREDIT REFERENCES

(Credit Cards, Car Loans, Electric Company, Etc.)

1. Name _____ Account # _____
 Address _____
 Telephone # _____

2. Name _____ Account # _____
 Address _____
 Telephone # _____

CHARACTER REFERENCES

We prefer business/community contacts; employer, teacher, minister, counselor, etc.

Please No Relatives

1. Name _____ Relationship _____
 Address _____
 Telephone # _____

2. Name _____ Relationship _____
 Address _____
 Telephone # _____

3. Name _____ Relationship _____
 Address _____
 Telephone # _____

EMERGENCY CONTACT

Primary Contact:

Name _____

Address _____

Telephone _____

Secondary Contact:

Name _____

Address _____

Telephone _____

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AUTHORIZATION

Authorization

I/We hereby authorize Calais Methodist Home, Inc, and its staff or authorized representative to contact any agencies, financial institutions, credit bureaus, landlord reference services, groups or organizations to obtain and verify any information for housing in programs administered/managed by Calais Methodist Home, Inc.

Conditions

I/We agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file with the management office and will remain in effect for as long as I reside in any apartment complex managed by Calais Methodist Home, Inc. I/We understand I have a right to review my file and correct any information that I can prove is incorrect.

Signatures

Head of Household Signature

Printed Name

Date

Spouse/Co-Tenant Signature

Printed Name

Date



I certify that the unit applied for at Calais Methodist Home, Inc. will be my household's permanent residence and I will not maintain a separate subsidized rental unit in a different location.

In order that I may be considered eligible for occupancy in an apartment financed and subsidized by Rural Development, I hereby state the preceding information is a true and complete statement of all expected income and assets of all residing in my household during the next 12 month period. I authorize inquires to be made to verify the statements above.

I/We do hereby certify that all information in this application is true and correct to the best of my/our knowledge and that I/we understand that false statements or information provided by me/us in connection with this application is punishable by law and will result in cancellation of this application or termination of tenancy after occupancy.

"The information regarding race, national origin, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through Rural Development, that Federal laws prohibiting discrimination against tenant application on the basis of race, color, national origin, religion, sex, familial status, age, and handicap are complied with. 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. However, if you chose not to furnish it, the owner is required to note the race/origin and sex of individual applicants on the basis of visual observation or surname."

SIGNATURES

Applicant

Co-Applicant

Date

Date

Applicant:

Race _____

National Origin _____

Sex _____

Co-Applicant:

Race _____

National Origin _____

Sex _____

