HOUSING AUTHORITY OF THE TOWN OF SIMSBURY
1600 HOPMEADOW STREET
SIMSBURY, CONNECTICUT 06070

DR. OWEN L. MURPHY APARTMENTS
AFFIDAVIT

Housing Authority of the Town of Simsbury
1600 Hopmeadow Street
Simsbury, CT 06070

To whom it may concern:

I have reviewed the attached application for housing and the statements contained therein are true and complete to the best of my knowledge and belief.

________________________________________________
Signature of person familiar with affairs of applicant--
Cannot be applicant or spouse

Applicant's Name: _____________________________________________

Date: _____________________________________________

Volume II, Chapter 128, Sec. 8-11a of the General Statutes of Connecticut, part (4):

"Any person who makes a false statement concerning the income of the elderly person for whom application for admission to a project under this part is made may be fined no more than five hundred dollars ($500) or imprisoned not more than six (6) months, or both."

“The Housing Authority of the Town of Simsbury is dedicated to providing affordable, safe, decent, sanitary and drug free housing for its residents.”
The State Elderly Housing Program is designed to aid elderly persons to obtain adequate housing. An elderly person is defined by law as a person aged sixty-two or over; or a person certified as being totally disabled under the Federal Social Security Act, who lacks the amount of income necessary to enable him/her to live in decent, safe and sanitary dwellings without financial assistance.

Be sure to report information accurately because it will help to decide who is eligible. Most of the questions are fairly clear. However, you should read the following explanation of certain questions.

ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE DISCLOSED

Income and Source
Report all income whether on a yearly, monthly or weekly basis so that it shows what you are receiving now. Be sure to include interest on savings accounts and dividends from investments.

Assets and Liabilities
If specific information about the value of your home or property is lacking, use the best available estimate of the market value. Assessed valuation is a possible source.

Monthly Rent
When the monthly electric, gas and heating fuel costs are not included in the rent; take the total of each for a year and divide it by twelve to obtain an average amount per month.

Housing Costs
Please use the same method for determining your average monthly costs as suggested in the question above.

Living Arrangements
Please be sure to report, in the space provided, if your living quarters have been condemned for occupancy or if you are being evicted.
Statement of Health

The attached form, to be completed and signed by your physician, is necessary. Needed is a general statement of your health, including any disabilities and limitations you may have. The statement must include the date of last office visit and the visit must have occurred within the past year. If you are a couple, a separate statement is required for each of you.

If you filed any tax return for the year previous to the application year, please attach a copy. Additional verification of income and medical expense may be required upon review of your application.

The accompanying Affidavit is to be completed by someone other than the applicant, familiar with the applicant's financial affairs. If the application is for a couple, the spouse's signature is not acceptable. The form does not have to be notarized.

The Applicant/Tenant Information Release Statement is a release for the Housing Authority of the Town of Simsbury to obtain personal, financial and medical information, and is required. It must be notarized in order to be accepted.

Those applicants whose applications indicate they may fall within the acceptable criteria will be invited to the housing office for an interview. Further assessment of the applicant will be made at the time of the interview. The applicant's responses will provide valuable insight into his/her ability to adapt to the elderly housing environment. At that time policies of the elderly housing complex may also be discussed such as leasing arrangements and Tenant Qualification Policy.

Applicants will be notified by mail of the disposition of their application.

If you need assistance in completing this application form, you may call us with questions at (860) 658-1147, or make an appointment at the Authority Office at the address given below between 9:00 AM and 3:00 PM, Monday through Friday. Applicants will not been seen without an appointment.

Mail or deliver the completed application to:

Housing Authority of the Town of Simsbury
1600 Hopmeadow Street
Simsbury, CT 06070
DR. OWEN L. MURPHY APARTMENTS
APPLICATION

Name of Applicant______________________________________________________________
Address_______________________________________________________________________
Telephone Number________________________Social Security #________________________
Date of Birth_____________________________Place of Birth___________________________
How long have you/your family lived in Connecticut?________________________________

SPONSOR (Family member or person responsible for the applicant) (Must have a Sponsor)
Name_________________________________________________________________________
Address_______________________________________________________________________
Telephone Number_________________________Relationship___________________________
How many people would be living in the apartment you are applying for?___________________

SOURCE OF INCOME
Social Security $__________________________________per__________________________
Disability $_______________________________________per___________________________
Pension $________________________________________ per___________________________
Dept. of Income Maintenance $_______________________per___________________________
Interest & Dividends $______________________________per___________________________
Annuities $_______________________________________per___________________________
Other Income  $___________________________________per___________________________
Total Annual Income $__________________________________________________________

ASSETS (Net Worth)
Stocks_________________________________________Amount_________________________
Bonds_________________________________________Amount_________________________
Bank Accounts_________________________________Amount_________________________
______________________________________________Amount_________________________
Home (Market Value)____________________________Amount_________________________
Other Property (Market Value)_____________________Amount_________________________
Other_________________________________________Amount_________________________
Outstanding Debt _______________________________Amount_________________________
If you rent your home or apartment, check here _____ and complete a-c.

a. Number of rooms (exclude bathroom) ______________

b. Location of unit in building (check one)
   1. First floor ______________
   2. Up and down ______________
   3. Second floor ______________
   4. Above second floor ______________

c. Monthly rent to nearest dollar
   1. Monthly electric bill to nearest dollar if not included in rent $_____________
   2. Monthly gas bill if not included in rent $_____________

If you own your own home check here _____ and complete a-c.

a. Number of rooms (exclude bathrooms) ______________

b. Type of home (check one)
   1. Rooms all on one floor ______________
   2. Rooms up and down ______________
   3. Rooms all on second floor ______________
   4. Rooms all above second floor ______________

c. Housing costs
   1. Taxes (average monthly) $_____________
   2. Monthly mortgage payment $_____________
   3. Insurance (average monthly) $_____________
   4. Electricity (average monthly) $_____________
   5. Gas (average monthly) $_____________
   6. Heating fuel (average monthly) $_____________

Living arrangements (check only items that apply to you)

a. With another family Yes______ No______
   If yes, with whom? _______________________________________________________

b. Living alone Yes______ No______

c. Home condemned for occupancy or being evicted Yes______ No______
   If being evicted, give reason ______________________________________________

d. Is present home generally satisfactory Yes______ No______
   If not, explain ___________________________________________________________

e. Do you own, rent or have living quarters other than already stated? Yes______ No______
   If yes, where? ___________________________________________________________

Plumbing facilities (check items that apply to your present home or apartment)

a. Flush toilet and bath in unit Yes______ No______

b. Hot and cold running water in unit Yes______ No______

c. Cold water only in unit Yes______ No______

Cooking facilities (check items that apply to your present home or apartment)

a. Stove in unit Yes______ No______

b. Refrigerator in unit Yes______ No______

Heating facilities (check items that apply to your present home or apartment)

a. Furnace - Oil or Gas ______________

b. Furnace - Coal or Wood ______________

c. Space heaters - Oil, Coal or Wood ______________

DATE______________SIGNATURE OF APPLICANT________________________________________

DATE______________SIGNATURE OF SPOUSE (If applicable)________________________________

DATE______________SIGNATURE OF PERSON WILLING TO ACCEPT RESPONSIBILITY FOR

APPLICANT(S) IN CASE OF EMERGENCY___________________________________________
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SIMSBURY, CONNECTICUT 06070

LANDLORD REFERENCES

<table>
<thead>
<tr>
<th>Applicant’s Name</th>
<th>Date</th>
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If current address is less than three years, you must provide previous Landlord information.

1) Current Address: _____________________________________________________
   Current Landlord Name: ____________________________________________
   Address: _________________________________________________________
   Phone No.: _______________________________________________________  

2) Previous Address: _________________________________________________
   Landlord Name: __________________________________________________
   Address: _________________________________________________________
   Phone No.: _______________________________________________________  

3) Previous Address: _________________________________________________
   Landlord Name: __________________________________________________
   Address: _________________________________________________________
   Phone No.: _______________________________________________________  

4) Previous Address: _________________________________________________
   Landlord Name: __________________________________________________
   Address: _________________________________________________________
   Phone No.: _______________________________________________________  

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PHYSICIAN STATEMENT

Client's Name__________________________________________________________________

The above named person is applying for residence in a housing complex designed for frail elderly persons. It is important that each resident be able to maintain him/herself in an independent manner without endangering either him/herself or others, in order to benefit from our facility's supportive services. It is equally important that each resident be emotionally stable, suited and capable of close community living, since the welfare and peace of mind of many other persons is involved. This information is confidential. Kindly complete and mail this form directly to the above address.

Patient's Name___________________________________Birthdate_______________________
Address_______________________________________________________________________
Height_________Weight_________Vision Impaired?_________Hearing Impaired?__________
How?_________________________________________________________________________
Blood Pressure_____________________________Pulse________________________________
Is patient being treated for high blood pressure?_______________________________________
Do any abnormal conditions exist for the following?
Back___________________________________Breasts_____________________Feet___________
Skin___________________________________Lungs______________________Heart_________________
If yes, explain condition__________________________________________________________
______________________________________________________________________________
Use of heart pacer?___________Use of walking aid?___________Use of oxygen?___________
Limitations/special precautions____________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Medication 1 _______________________________Condition__________________________
Medication 2 _______________________________Condition__________________________
Medication 3 _______________________________Condition__________________________
Drug Allergies_________________________________________________________________

Continued on other side
Date of last illness_____________________Date of last hospitalization____________________

Any history of alcoholism?_________________________________________________________

Any history of emotional illness?___________________________________________________

If patient is classified as disabled under Social Security Administration guidelines, please state nature of disability and date disability began._________________________________________

Additional medical information____________________________________________________

______________________________________________________________________________

How long have you known patient?___________________

Mental Status:  Normal________  Forgetful________ Confused________ Disoriented________

Details________________________________________________________________________

______________________________________________________________________________

Disabling conditions_____________________________________________________________

______________________________________________________________________________

Nursing care or supervision required_______________________________________________

______________________________________________________________________________

Special therapy or treatment required______________________________________________

______________________________________________________________________________

Special diet required_____________________________________________________________

______________________________________________________________________________

Additional information___________________________________________________________

______________________________________________________________________________

Do you feel that this patient is capable of independent living?_________________________

Notes:________________________________________________________________________

______________________________________________________________________________

This is to certify that on (date)_____________________, the above named was given a physical examination by me and that a record of my findings is on file in my office.

Name_________________________________________________________________________

Address_______________________________________________________________________

Telephone______________________________Medical License #________________________

Signature__________________________________________________________________M.D.
I understand that the Housing Authority of the Town of Simsbury is required by Connecticut State Law to verify income and information relative to all applications for admission to the Elderly Housing Program and to re-examine annually the income of all residents.

I hereby authorize the Housing Authority of the Town of Simsbury to obtain and/or verify any information relative to my application, or re-examination for continued occupancy. I also give permission for the Housing Authority to obtain information concerning my financial obligations, landlord references, or medical expenses. I also authorize the Housing Authority to conduct credit and criminal background checks.

I authorize permission for the release of information regarding character references and medical history, including disability, frequency and duration of treatment, and information required to establish evidence of rehabilitation or my ability to independently maintain my apartment.

I 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 Housing Authority of the Town of Simsbury and will stay in effect until terminated in writing by the undersigned.

SIGNATURE______________________________________________________

WITNESS_________________________________________________________

DATE_____________________________________________________________

Affirmed and sworn to before me this _______ day of___________, 20_______

______________________________________________________________
NOTARY PUBLIC