Azalea Gardens

700 Spring Avenue
Murfreesboro, NC 27855
(252) 398-5762

Thank You for your interest in Azalea Gardens Apartments, offering 1 and 2 bedroom apartments. Enclosed is our rental application that must be filled out completely. If a question does not apply to your situation, please answer N/A. We also ask that you use a pen when completing the application. Again, thank you for inquiring about Azalea Gardens Apartments!

The following income restrictions apply for all persons applying for housing.

Maximum Adjusted Income

	1 Person	2 Person	3 Person	4 Person	5 Person
Very Low	25,700	29,350	33,000	36,650	39,600
Low	41,100	46,950	52,800	58,650	63,350
Moderate	46,600	52,450	58,300	64,150	68,850

	1BR	**2BR**
Rent Schedule:	31 @ $0 to $961	2 @ $0 to $1,001

Rent Based on Income - Rental Assistance Available

Utility Allowance: (estimated utility cost per month – based on average utility cost for electricity)	$62	$98
Security Deposit:	$770	$810
Minimum Income Requirement: With RA	None	

Pet Policy: Limit 1 Pet, Max. Weight – 25 lbs. $150 deposit (refundable) $150 pet fee (non-refundable)

Age Requirement: 62 years of age or older, or handicapped, or disabled

No Smoking Permitted Anywhere

Application Requirements

1. **Completed and signed application.**
2. **Application fee is $35 for all household members 18 years of age and older paid by check or money order to Evergreen Construction.**
3. **Enclose a copy of each household member(s) birth certificate.**
4. **Enclose a copy of each household member(s) social security card.**

Return the above information to: Azalea Gardens Apartments
700 Spring Avenue
Murfreesboro, NC 27855

EQUAL HOUSING OPPORTUNITY

This institution is an equal opportunity provider and employer

01-01-2025 RD

EQUAL HOUSING OPPORTUNITY

EVERGREEN
CONSTRUCTION COMPANY

FOR OFFICE USE – IN PENCIL
APT. COMMUNITY:
DATE REC'D:
TIME REC'D:
MGR INITIALS:

Rental Application

Please print in ink, answer NO or N/A where applicable, initial all corrections, and do not use white out. All Blanks must be completed

APPLICANT INFORMATION

Applicant's Full Name:	Desired Move in Date:
Bedroom Size Requested:	Email Address:

RESIDENCE INFORMATION
* **5** YEARS OF RESIDENTIAL HISTORY MUST BE PROVIDED*

Current Residence	Street:		
City:	State:	ZIP:	Telephone:
Cell Phone Number:		Drivers License Number:	
Lived here from: to:		Do you Rent ☐ or Own ☐	
Reason for moving:			
Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:
Previous Residence	Street:		
City:	State:	ZIP:	
Lived here from: to:		Rent ☐ or Own ☐	
Reason for moving:			
Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:
Previous Residence	Street:		
City:	State:	ZIP:	
Lived here from: to:		Rent ☐ or Own ☐	
Reason for moving:			
Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:

CO-APPLICANT INFORMATION

Co-Applicant's Full Name:

RESIDENCE INFORMATION – CO-APPLICANT
* **5** YEARS OF RESIDENTIAL HISTORY MUST BE PROVIDED*

Current Residence	Street:		
City:	State:	ZIP:	Telephone:
Cell Phone Number:		Drivers License Number:	
Lived here from: to:		Do you Rent ☐ or Own ☐	
Reason for moving:			

Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:
Previous Residence	Street:		
City:	State:	ZIP:	
Lived here from: to:		Rent ☐ or Own ☐	
Reason for moving:			
Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:
Previous Residence	Street:		
City:	State:	ZIP:	
Lived here from: to:		Rent ☐ or Own ☐	
Reason for moving:			
Landlord Name:			
Landlord Address:			
City:	State:	ZIP:	Telephone:

HOUSEHOLD COMPOSITION

DIRECTIONS: PLEASE COMPLETE THE TABLE BELOW LISTING EACH MEMBER OF THE HOUSEHOLD, INCLUDING CARE ATTENDANTS, WHETHER OR NOT THOSE MEMBERS ARE RELATED. INCLUDE ALL MEMBERS WHO YOU ANTICIPATE WILL LIVE WITH YOU AT LEAST 50% OR MORE OF THE TIME DURING THE NEXT 12 MONTHS. (A FULL TIME STUDENT IS ANYONE WHO IS ENROLLED FOR AT LEAST FIVE CALENDAR YEAR MONTHS FOR THE NUMBER OF HOURS OR COURSES WHICH ARE CONSIDERED FULL-TIME ATTENDANCE BY THAT INSTITUTION. THE FIVE MONTHS NEED NOT BE CONSECUTIVE).

LIST EACH PERSON LIVING IN THE UNIT

	Name	Relation to Head	Birth Date	Gender	Student	Employed	Marital Status	SS Number
1		HEAD		M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
2				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
3				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
4				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
5				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
6				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	
7				M ☐ F ☐	Y ☐ N ☐ F/T ☐ P/T ☐	Y ☐ N ☐ How Long_____	Single ☐ Married ☐ Separated ☐ Widowed ☐	

Do all of the household members reside in the household 100% of the time? Y ☐ N ☐ If no, please list those not living in the household 100% of the time:

Anticipated changes in household size within the next 12 months? Y ☐ N ☐ If yes, explain:

Anticipated change in number of students within the next 12 months? Y ☐ N ☐ If yes, explain:

CARE ATTENDANT

Will you have a Care Attendant living with you? Y ☐ N ☐ If yes, F/T ☐ or P/T ☐

Name of Care Attendant:

Address:

City:	State:	ZIP:	Telephone:

GENERAL INFORMATION

Have you, your spouse, or any other proposed occupant ever:

1. Been arrested and charged with a misdemeanor or felony? Y ☐ N ☐
If yes, who_____ in what state _____ what year_____

2. Been required to register as a sex offender? Y ☐ N ☐
If yes, who_____ in what state _____ what year_____

3. Been evicted? Y ☐ N ☐
If yes, when _____ where_____

Do you have a Section 8 voucher or certificate? Y ☐ N ☐

Do you have any pets? Y ☐ N ☐ If yes, list breed and weight:

Pets are Only permitted in senior properties

How did you hear about our apartment community?

EMERGENCY CONTACT
(PLEASE PROVIDE INFORMATION FOR TWO PEOPLE NOT PLANNING TO OCCUPY THE PREMISES WHOM WE MAY CONTACT IN THE EVENT OF AN EMERGENCY, OR TO LOCATE YOU)

Name:	Relationship:	Telephone:	
Address:	City:	State:	Zip:
Name	Relationship:	Telephone:	
Address:	City:	State:	Zip:

AUTOMOBILE INFORMATION

Model:	Make:	Color:	Tag #:
Model:	Make:	Color:	Tag #:

Program regulations for this community require that all applicants/tenants reveal all sources of income and assets. This application is not considered complete and therefore cannot be processed until the following questionnaire of income and assets have been completed by each household member 18 years of age and older (not required for care attendants).

NAME:

INCOME AND ASSETS
(EACH HOUSEHOLD MEMBER 18 YRS AND OLDER MUST COMPLETE SEPARATE INCOME AND ASSETS FORMS)

Type of Asset **Including any accounts held for dependents**	How Many	Estimated Value	Source Contact for Verification (list each separately)
Checking Account Y ☐ N ☐		$ $	Institution Name: Telephone: Institution Name: Telephone:
Savings Account Y ☐ N ☐		$ $	Institution Name: Telephone: Institution Name: Telephone:
Debit Cards Y ☐ N ☐ NOT including debit cards related to the accounts listed above		$ $	Institution Name: Telephone: Institution Name: Telephone:
Certificates of Deposits Y ☐ N ☐		$	Institution Name: Telephone:
Money Market Funds Y ☐ N ☐		$	Institution Name: Telephone:
Mutual Funds/Stock Y ☐ N ☐		$	Institution Name: Telephone:
Treasury Bills Y ☐ N ☐		$	Institution Name: Telephone:
IRA or 401k Y ☐ N ☐		$	Institution Name: Telephone:
Company Retirement Accounts Y ☐ N ☐		$	Institution Name: Telephone:
Annuities Income Y ☐ N ☐		$	Institution Name: Telephone:
Life Insurance Policies (Whole Life) Y ☐ N ☐		$	Institution Name: Telephone:
Pension Funds Y ☐ N ☐ (Account Not receiving payments on a regular basis)		$	Institution Name: Telephone:
Trust Accounts Y ☐ N ☐ If yes, is it revocable? Y ☐ N ☐		$	Institution Name: Telephone:
Personal Property held for Investment Y ☐ N ☐		$	Institution Name: Telephone:
Mortgage or Deed of Trust Y ☐ N ☐		$	Institution Name: Telephone:
Cash on Hand including Cash Applications i.e. Paypal, Venmo, CashApp, etc Y ☐ N ☐		$	List all sources or accounts:
House/Real Estate Y ☐ N ☐		$	Institution Name: Telephone:
Rental Property Y ☐ N ☐		$	Institution Name: Telephone:
Other Investments Y ☐ N ☐		$	Institution Name: Telephone:
Have you received any lump sum payments such as the following:			
Inheritances Y ☐ N ☐		$	Details:
Lottery or other winnings Y ☐ N ☐		$	Details:
Insurance Settlements Y ☐ N ☐		$	Details:
Workers Compensation Settlements Y ☐ N ☐		$	Details:
Social Security Disability Settlements Y ☐ N ☐		$	Details:
Unemployment Compensation Settlements Y ☐ N ☐		$	Details:
VA Disability Settlements Y ☐ N ☐		$	Details:
Severance Pay Y ☐ N ☐		$	Details:
Capital Gains Y ☐ N ☐		$	Details:
Other (Including Crypto Currency) Y ☐ N ☐		$	Details:

Have you disposed of any assets for less than Fair Market Value within the last two years? (Please state if the sale was due to foreclosure, bankruptcy or divorce.) Y ☐ N ☐ If yes, explain:

Initial_____

Income			
Type of Income	How Many	Estimated Monthly Amount	Source Contact for Verification
Employment (Wages & Salary) Y ☐ N ☐ **How long?** _____ If less than 1 year, start date: _____		$ $	Institution Name: Address: Telephone: Institution Name: Address: Telephone:
Income from a Business or Profession Y ☐ N ☐		$	Institution Name: Telephone:
Military Pay, including all allowances Y ☐ N ☐		$	Institution Name: Telephone:
Social Security: **Include any amounts received for household dependents** Y☐ N ☐		$	Institution Name: Telephone:
SSI: **Include any amounts received for household dependents** Y☐ N ☐		$	Institution Name: Telephone:
Disability and Death Benefits (other than SSI) **Include any amounts received for household dependents** Y☐ N ☐		$	Institution Name: Telephone:
TANF/Work First or other Public Assistance Y ☐ N ☐		$	Institution Name: Telephone:
Alimony Y ☐ N ☐		$	Institution Name: Telephone:
Child Support (include all support whether court ordered or not) Y ☐ N ☐		$	Institution Name: Telephone:
Unemployment Compensation Y ☐ N ☐		$	Institution Name: Telephone:
Workers' Compensation Y ☐ N ☐		$	Institution Name: Telephone:
Severance Pay Y ☐ N ☐		$	Institution Name: Telephone:
Retirement Income Y ☐ N ☐		$	Institution Name: Telephone:
Pensions Y ☐ N ☐ (Receiving payments on a regular basis)		$	Institution Name: Telephone:
Annuities Income Y ☐ N ☐		$	Institution Name: Telephone:
Insurance Policies Income Y ☐ N ☐		$	Institution Name: Telephone:
Scholarships, Grants, Educational Entitlements **Include any amounts received for household dependents** Y ☐ N ☐		$	Institution Name: Telephone:
Income from Rental Property Y ☐ N ☐		$	
Work Study Programs Y ☐ N ☐		$	Institution Name: Telephone:
Long Term Care Payments Y ☐ N ☐		$	Institution Name: Telephone:
Income from Training Y ☐ N ☐		$	Institution Name: Telephone:
Other Income (Including GoFndMe) Y ☐ N ☐		$	Institution Name: Telephone:
Regular Recurring Gifts Y ☐ N ☐ (Such as but not limited to: Receiving monetary gifts or non-cash contributions from persons outside the household for rent, utilities, groceries, clothing and/or misc household supplies)		$	Please explain:

I understand that the above information is being collected to determine my eligibility for residence. I authorize the owner/manager to verify information provided on this application and my signature is my consent to obtain such verification. I certify that I have revealed all assets currently held or previously disposed of and that I have no other assets other than those listed on this form (other than personal property). I further certify that the statements made in this application are true and complete to the best of my knowledge and belief and am aware that false statements are punishable under Federal law.

I understand that this application and all related inquires will be used only for its relevance to screening and occupancy at this property.

Signature:_____ Date: ____/____/_____

C. Miscellaneous Information

1. Do you pay any child care expenses for children age 12 or younger that enables a family member to go to work or to school? (Note: This amount should not exceed the amount earned at work or should not exceed a sum reasonably expected to cover class time and travel time to and from classes. Also, for this expense to be allowed as a deduction from income, the amount is not to be paid to a family member living in the household, is not to be reimbursed by an agency or individual and is allowed only if there is no adult member of the household capable of providing the care.)

( ) Yes ( ) No Estimated Annual Amount_____

2. Do you have any handicapped assistance expenses which enable a family member (including the handicapped members) to work. (Note: This deduction may be given for expense amounts which exceed 3% of annual income provided they are not paid to a member of the household or reimbursed by an agency or individual.)

( ) Yes ( ) No Estimated Annual Amount_____

DEFINITION OF DISABILITY AND HANDICAP

Individual with disability. A person is considered disabled if the person meets the criteria of either of the following:

1. The person has an inability to engage in any substantial gainful activity, but with use of auxiliary apparatus can otherwise participate in gainful activity, by reason of any medically determinable physical or mental impairment, where the disability:

a. Has lasted or can be expected to last for a continuous period of not less than 12 months, or which can be expected to result in death, and

b. Substantially impedes the ability to live independently, and

c. Is of such a nature that such ability could be improved by more suitable housing conditions, or

d. In the case of a sight impaired person who is at least 55 years old (within the meaning of sight impairment as determined in Section 223 of the Social Security Act), is unable, because of the sight impairment, to engage in substantial gainful activity in which he/she has previously engaged with some regularity over a substantial period of time.

e. Receipt of veteran's or Social Security Disability payments benefits for disability, whether service-oriented or otherwise does not automatically establish disability.

2. The person has a developmental disability; a severe, chronic disability which:

a. Is attributable to a mental or physical impairment or combination of mental or physical impairment; and

b. Was manifested before age 22; and

c. Is likely to continue indefinitely; and

d. Results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-Care
(2) Receptive and expressive language
(3) Learning
(4) Mobility
(5) Self-direction
(6) Capacity for independent living
(7) Economic self-sufficiency

e. Reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, or treatment, or for other services which are of lifelong or extended duration and are individually planned and coordinated.

Individual with handicap.

1. A person with a physical or mental impairment that:

a. Is expected to be of long-continued and indefinite duration; and

b. Substantially impedes the person or is of such a nature that the person's ability to live independently could be improved by more suitable housing conditions.

2. The term handicap further means, with respect to a person, a physical or mental impairment which substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment. THIS TERM DOES NOT INCLUDE CURRENT ILLEGAL USE OF OR ADDICTION TO A CONTROLLED SUBSTANCE. As used in this definition:

a. Physical or mental impairment includes:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

b. Major life activities means functions such as caring for one's self, performing major tasks, walking, seeing, hearing, speaking, breathing, learning and working.

c. Has a record of such an impairment means has a history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more of major life activities.

d. Is regarded as having an impairment means:

(1) Has a physical or mental impairment that does not substantially limit one or more major life activities but that is treated by another person as constituting such a limitation;

(2) Has a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment; or

(3) Has one of the impairments defined in paragraph 2 a (1) and 2 a (2) of this definition but is treated by another person as having such an impairment.

Persons which meet the definition of disabled or handicapped qualify for a $400.00 deduction to their annual income when determining rent contribution and certain other deductions. If after reading the definitions above you feel that you qualify and would like to request this adjustment to your income, please indicate in the space provided:

( ) Yes, I feel that I meet the definition of handicapped and/or disabled as defined above and would therefore like to request the $400.00 adjustment to income.

( ) No, I feel that I do not meet the definition of handicapped or disabled as defined above and therefore do not request the $400.00 adjustment to income.

If you have indicated your desire to request this adjustment, then we will need only sufficient information (documentation) to confirm your qualification for the handicapped/disabled status. Failure to provide this information may result in the denial of these deductions.

Would you like to request a handicapped designed unit?

( ) Yes

( ) No

Would you like to request reasonable accommodations/modifications to the unit?

( ) Yes, I would like to request _____

_____

( ) No

FOR CONGREGATE HOUSING ONLY

Would you like to request a specific service or services?

( ) Yes, I would like to request _____

_____

( ) No

MEDICAL EXPENSE QUESTIONNAIRE

*** FOR ELDERLY, HANDICAPPED OR DISABLED ONLY ***

1. Are you currently under the care of a physician, optometrist, ENT, etc. where you are having to pay for bills not covered by medical insurance? ( ) Yes ( ) No

   If yes, please provide the following:

   Name of Physician _____ Name of Physician _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

   Name of Physician _____ Name of Physician _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

2. Are you currently having to take medication that is not covered by medical insurance? ( ) Yes ( ) No

   If yes, provide the following:

   Name of Pharmacy _____ Name of Pharmacy _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

   Name of Pharmacy _____ Name of Pharmacy _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

3. Are you currently paying for hospital bills not covered by medical insurance? ( ) Yes ( ) No

   If yes, please provide the following:

   Name of Hospital _____ Name of Hospital _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

   Total amount owed $_____ Total amount owed $_____

   What is the estimated amount that you will spend over the next 12 months to reduce the amount owed? $_____

   What is the estimated amount that you will spend over the next 12 months to reduce the amount owed? $_____

4. Do you pay medical insurance premiums? ( ) Yes ( ) No

   If yes, please provide the following:

   Name of Insurance Co. _____ Name of Insurance Co. _____

   Address _____ Address _____

   _____ _____

   Phone _____ Phone _____

   Monthly premium amount $_____ Monthly premium amount $_____

I (we) understand that this application must be filled out completely and accurately. I (we) certify that the information provided is accurate and I (we) understand that any misrepresentations will disqualify me (us). I (we) further certify that the housing occupied on these premises will be my (our) permanent residence and I (we) do not/will not maintain a separate subsidized rental unit at any other location.

By signing this application, I (we) hereby authorize the management (or agent) of this complex, for the purpose of this application, to contact and obtain any information required from any of the individuals or entities listed on this application, or from any other individuals or entities as may be required. Management further reserves the right to release this information for purposes of collecting outstanding debts.

I (we) understand that the managing agent will verify, in writing through a third party the information provided on this application.

I (we) also understand that my household wages are subject to being verified through a third party source(s) by agencies designated by the U.S. Federal Government to administer this housing program.

WARNING

Section 1001 of the Title 18, United States Code provides, "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain false, fictitious or fraudulent statements or entry, shall be fined under this title or imprisoned not more than five years, or both.

If this application is approved, one month's prorated rent and security deposit or partial payment of deposit must be paid and lease and tenant certification must be executed in advance before occupancy of the apartment. NO REFUND WILL BE MADE except to comply with state and federal guidelines. All rent is due and payable in advance on the FIRST DAY OF THE MONTH.

Application will not be processed until applicant pays application fee of $_____. Fee must be in the form of a check or money order payable to Evergreen Construction Co. Fee is Non-Refundable.

BY SIGNING BELOW, I CERTIFY I HAVE READ AND UNDERSTAND ALL THE ABOVE

Signatures:

Applicant:_____ Date:___/___/_____

Co-Applicant:_____ Date:___/___/_____

Adult household member:_____ Date:___/___/_____

Adult household member:_____ Date:___/___/_____

How did you hear about our apartment community? Newspaper ( ) Phonebook ( ) Resident ( )

Drive-by ( ) Flyer/Brochure ( ) Other ( ) Explain _____

Date possession of apartment desired _____

Comments:

_____

_____

Please review the statement below and provide the requested information, if you are willing:

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

Applicant:	Ethnicity Hispanic or Latino ☐ Not Hispanic or Latino ☐	Race American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐	Gender Male ☐ Female ☐	*I do not wish to furnish this information ☐ _____ (initial)
Co-Applicant:	Ethnicity Hispanic or Latino ☐ Not Hispanic or Latino ☐	Race American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐	Gender Male ☐ Female ☐	*I do not wish to furnish this information ☐ _____ (initial)

*Race/national origin and sex of individual applicants were completed based on visual observation _____ (MGR initial)

TENANT RELEASE AND CONSENT

I/We _____, the undersigned hereby authorize all

persons or companies in the categories listed below to release without liability, information

regarding employment, income, and/or assets to _____ for
(owner or agent)

purposes of verifying information on my/our apartment rental application.

INFORMATION COVERED
I/We understand that previous or current information regarding me/us may be needed. Verifications and inquiries that may be requested include, but are not limited to: personal identity; employment, income, and assets; medical or child care allowances. I/We understand that this authorization cannot be used to obtain any information about me/us that is not pertinent to my eligibility for and continued participation as a Qualified Tenant.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED
The groups or individuals that may be asked to release the above information include, but are not limited to:

Past and Present Employers	Welfare Agencies	Veterans Administration
Previous Landlords (including	State Unemployment Agencies	Retirement Systems
Public Housing Agencies)	Social Security Administration	Banks and Other Financial
Support and Alimony Providers	Medical and Child Care Providers	Institutions

Colleges, Universities, and Higher Educational institutions
Utility Company _____

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 and will stay in effect for a year and one month from the date signed. I/We understand I/we have a right to review this file and correct any information that is incorrect.

SIGNATURES

_____	_____	__/____/_____
Applicant/Resident	(Print Name)	Date
_____	_____	__/____/_____
Co-Applicant/Resident	(Print Name)	Date
_____	_____	__/____/_____
Adult Member	(Print Name)	Date
_____	_____	__/____/_____
Adult Member	(Print Name)	Date

NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF A TAX RETURN IS NEEDED, IRS FORM 4506, "REQUEST FOR COPY OF TAX FORM" MUST BE PREPARED AND SIGNED SEPERATELY.