

RENTAL APPLICATION FOR PROJECT-BASED APARTMENTS
 PENDER COUNTY HOUSING DEPARTMENT
 P O BOX 1149 BURGAW, NC 28425 PHONE: 910.259.1208 FAX: 910.259.13431

PROVIDE ALL INFORMATION REQUESTED AS IT APPLIES TO YOUR FAMILY. DO NOT LEAVE BLANKS.
 (INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED)

APPLICANT INFORMATION:

Name: _____ Driver's License #: _____ State Issued: _____

Current Address: _____

Mailing Address (if Different): _____

Preferred Phone #: (____) _____ E-mail Address: _____

Landlord Information (if you live with a family member, that person is your landlord):

Name of Current Landlord: _____ Phone #: (____) _____

Current Landlord Address: _____

Name of Previous Landlord: _____ Phone #: (____) _____

Previous Landlord Address: _____

ATTACH A COPY OF THE SOCIAL SECURITY CARD & BIRTH CERTIFICATE FOR EACH PERSON LISTED BELOW. ATTACH COPIES OF A CURRENT PHOTO IDENTIFICATION CARD FOR EACH ADULT IN THE FAMILY. ATTACH PROOF OF LEGAL CUSTODY FOR ALL CHILDREN IN YOUR CARE WHO ARE NOT THE BIOLOGICAL CHILDREN OF A MEMBER OF YOUR HOUSEHOLD.

HOUSEHOLD MEMBER NAME	RELATIONSHIP TO HEAD OF HOUSEHOLD	BIRTHDATE	AGE	SOCIAL SECURITY #	WORKING? (ANSWER YES OR NO)	STUDENT? (ANSWER YES OR NO)
	SELF					

DO YOU EXPECT ANY CHANGES IN YOUR FAMILY IN THE NEXT 12 MONTHS (SUCH AS A NEW BABY, MARRIAGE) INCLUDING ANY UPCOMING CHANGES IN HOUSEHOLD INCOME/JOB? _____

ARE YOU: MARRIED DIVORCED SEPARATED SINGLE WIDOWED



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HOUSEHOLD INCOME, EXPENSES AND ASSETS

(LIST ALL JOBS, BENEFITS, ANY OTHER INCOME & ALL ASSETS OF ALL HOUSEHOLD MEMBERS, USE A SEPARATE SHEET OF PAPER IF NECESSARY)

NAME OF PERSON WHO WORKS:		
WHERE DOES HE/SHE WORK?		WHAT IS HIS/HER JOB TITLE:
WORK ADDRESS:		WORK TELEPHONE #:
SUPERVISOR NAME:	HOW LONG HAVE YOU BEEN WORKING THERE? _____ <small>(choose one)</small> WKS MOS YRS	RATE OF PAY: \$
HOW OFTEN DO YOU GET PAID? <small>(choose one)</small> WEEKLY BI-WEEKLY MONTHLY		HOW MANY HOURS DO YOU WORK EACH WEEK?

NAME OF PERSON WHO WORKS:		
WHERE DOES HE/SHE WORK?		WHAT IS HIS/HER JOB TITLE:
WORK ADDRESS:		WORK TELEPHONE #:
SUPERVISOR NAME:	HOW LONG HAVE YOU BEEN WORKING THERE? _____ <small>(choose one)</small> WKS MOS YRS	RATE OF PAY: \$
HOW OFTEN DO YOU GET PAID? <small>(choose one)</small> WEEKLY BI-WEEKLY MONTHLY		HOW MANY HOURS DO YOU WORK EACH WEEK?

DO YOU OR DOES ANYONE IN YOUR HOUSEHOLD RECEIVE ANY OF THE FOLLOWING?

TYPE	YES	NO	IF YES, HOW MUCH?	PER WEEK/MONTH	NAME OF PERSON RECEIVING
WORK FIRST/WELFARE			\$		
CHILD SUPPORT/ALIMONY			\$		
UNEMPLOYMENT BENEFITS			\$		
SOCIAL SECURITY/SSI/SSDI			\$		
FOOD STAMPS			\$		
VA Benefits/Pensions			\$		
Pension/retirement Benefits			\$		
Gifts/Help from people not in your household			\$		
Self-employment income			\$		
Financial Aid			\$		



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DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE ANY CHECKING ACCOUNTS, SAVING ACCOUNTS, REAL ESTATE, ETC.?

NO – EXPLAIN HOW YOU PAY BILLS: _____

YES - LIST ACCOUNTS, TYPE AND BALANCE/CURRENT VALUE. (YOU MUST LIST ALL ACCOUNTS/ASSETS EVEN IF THE BALANCE IS 0)

Account type/Asset Type (checking/savings/ Land/ Insurance/CDs/Collectibles)	Current Balance or Value	Name of Bank/ Financial Institution (if any)	Account # (if any)	Name of person who owns the asset
	\$			
	\$			

HAVE YOU GIVEN AWAY ANY ASSETS IN THE LAST 2 YEARS FOR LESS THAN FULL VALUE (including cash)?
 YES NO IF YES, PLEASE EXPLAIN

CHILDCARE:

DO YOU PAY FOR CHILD CARE? YES NO IF YES, COST: \$_____ PER (choose one) WK MO

WHO PAYS THE OUT OF POCKET COST OF YOUR CHILD CARE EXPENSES? _____

IS THE HEAD OF HOUSEHOLD HANDICAPPED OR DISABLED? YES NO

DO YOU HAVE OUT OF POCKET COSTS FOR MEDICAL EXPENSES? YES NO

PLEASE IDENTIFY ANY SPECIAL **HOUSING** NEEDS REQUIRED AS A RESULT OF A DISABILITY:

• HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD EVER BEEN CONVICTED OF ANY TYPE OF CRIMINAL ACTIVITY OF ANY: NO YES - If yes, explain when & where:

• ARE YOU LIVING IN SUBSIDIZED HOUSING OR RECEIVING RENTAL ASSISTANCE NOW? YES NO

• HAVE YOU LIVED IN SUBSIDIZED HOUSING OR RECEIVING RENTAL ASSISTANCE IN THE LAST 10 YEARS?
 NO YES- List where & when: _____

• HOW DID YOU HEAR ABOUT OUR PROGRAM?

NEWSPAPER FLYER BULLETIN RESIDENT OTHER: _____



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IN CASE WE CANNOT REACH YOU, WHO MAY WE CONTACT IN THE EVENT OF AN EMERGENCY:

NAME OF CONTACT	RELATIONSHIP TO YOU	PHONE NUMBER
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CONTACT'S MAILING ADDRESS

BY SIGNING THIS APPLICATION, I/WE HEREBY SPECIFICALLY AUTHORIZE THE MANAGEMENT &/OR ITS AGENT, FOR THE PURPOSES OF THIS APPLICATION, TO CONTACT AND OBTAIN ANY INFORMATION REQUIRED FOR ANY OF THE INDIVIDUALS OR ENTITIES LISTED ON THIS APPLICATION OR FROM ANY OTHER INDIVIDUALS OR ENTITIES AS MAY BE REQUIRED.

I/WE CERTIFY WITH MY/OUR SIGNATURE THAT THIS APPLICATION IS FILLED OUT COMPLETELY AND ACCURATELY. I/WE CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND I/WE UNDERSTAND THAT ANY MISREPRESENTATION OF INFORMATION WILL CAUSE ME/US TO BE INELIGIBLE TO PARTICIPATE IN THE PROGRAM FOR WHICH I/WE HAVE APPLIED. I/WE ALSO UNDERSTAND THAT THE HOUSING AUTHORITY WILL VERIFY, IN WRITING THROUGH A THIRD PARTY (WHEN EVER POSSIBLE) THE INFORMATION PROVIDED ON THIS APPLICATION.

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any Department or Agency of the U.S. as to any matter within its jurisdiction.

Signature of Applicant/Head of Household	Print Name	Date
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Signature of Spouse/Co-head	Print Name	Date
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Signature of Other Adult	Print Name	Date
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Signature of Other Adult	Print Name	Date
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FOR MANAGEMENT USE:

DATE & TIME RECEIVED:

INITIALS OF STAFF PERSON REVIEWING APPLICATION: _____

