



# Greens at Avenel

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 Avenel, NJ 07001  
 Phone: 732.443.3880  
 Fax: 908.248.9672  
 Email: GreensAtAvenel@penrose.com  
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To be completed by office staff:  
 Application Number \_\_\_\_\_  
 Date Application Rec'd \_\_\_\_\_  
 Time Application Rec'd \_\_\_\_\_  
 Initials of Staff Member \_\_\_\_\_

## HEAD OF HOUSEHOLD

M	F
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NAME: \_\_\_\_\_ SSN: \_\_\_\_\_  
 (First) (Middle Initial) (Last)

CURRENT ADDRESS: \_\_\_\_\_ HOME #: \_\_\_\_\_  
 (House #) (Street Name) (Apt. #)

(City) (State) (Zip Code) WORK #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ D.O.B: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ DRIVER LICENSE STATE: \_\_\_\_\_  
 DRIVER LICENSE NUMBER: \_\_\_\_\_

## HOUSEHOLD MEMBERS

A non-refundable \$25 application fee per adult household member is required.

Name	DOB	M/F	Relationship	Soc. Sec. Number	DL State & Number

## ANNUAL HOUSEHOLD INCOME

Gross Employment/Wages	\$
Social Security Income	\$
Social Security Disability Income	\$
Public Assistance (Welfare/TANF)	\$
Child Support	\$
Pension	\$
Other Income (Please Specify):	\$



**Preferences for Determining Waiting List Position (if applicable)**

Do you or any member of your household have a SPECIAL NEEDS?*			Y	N
Is the Head of Household or Spouse 62 years of age or older or disabled?			Y	N
Are you currently employed?			Y	N
Are you a student or recent graduate of an educational or training program?			Y	N
Were you involuntarily displaced due to a natural disaster?			Y	N
Are you a New Jersey resident affected by Superstorm Sandy?			Y	N
Are you a current resident of Woodbridge Township?			Y	N
Are you homeless?			Y	N
Do you require a unit with special features? (e.g. unit for mobility impaired, visually impaired, hearing impaired, walk-in shower, grab bars, no steps, etc.)			Y	N
If yes above, please circle features required:				
Unit for mobility impaired		Unit for visually impaired		Unit for hearing impaired
Grab bars		No steps		Other:
Describe:				

**\*The NJHMFA definition of Special Needs includes the following:** individuals with mental illness, individuals with physical or developmental disability, victims of domestic violence, ex-offenders and youth offenders, youth aging out of foster care, runaway and homeless youth, homeless individuals, disabled and homeless veterans, individuals with AIDS/HIV, and individuals 18 years and over coming out of a nursing home.

I hereby certify that the above is true and correct and complete to the best of my knowledge. I understand that any false statement or misrepresentation will be grounds for expulsion from the program and/or prosecution under Title 18, Section 1001 of the US Code.

I, \_\_\_\_\_, hereby give my permission for a credit and criminal background check, which is part of the application process.

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Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Types of Program Assistance (For Office Use ONLY)**

**\*\*Important: You must notify us promptly should any information on this application change**

Tax Credit  50%  60%

ACC  30

April 2021

