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BCUW/Madeline Housing Partners, LLC

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# RENTAL APPLICATION CHECKLIST

The following forms are **REQUIRED** in order for your application to be considered:

- Questionnaire
- Completed application
- Copies of identification: Picture ID, Birth Certificate, Social Security Card, Driver's License (if applicable)
- Three months of bank statements and paystubs
- Most recent documentation for all sources of income (i.e., SSI award letter, child support, alimony, IRA and 401K investments, pension payments, etc.)
- Copies of the last two years' 1040 forms filed with the IRS
- Disability certification form completed by a licensed physician
- Proof of current residence (i.e., cable bill, mail, etc.)
- Proof of medical insurance/coverage
- Copy of the first page of the DDD Support Plan (if applicable)

**Please mail completed applications to:**

Madeline Corporation  
Attn: Ridgewood Application  
555 10<sup>th</sup> Street  
Palisades Park, NJ 07650

**Completed applications must be postmarked by June 17<sup>th</sup>, 2021.**

Incomplete applications will not be considered.

**For questions or assistance, please contact our Housing Services Coordinator at 201-291-0619 or [housing@bergenunitedway.org](mailto:housing@bergenunitedway.org).**

# QUESTIONNAIRE

Please answer the questions below, so we can learn more about you.

1. What do you enjoy doing in your free time?

- |  |  |
|--|--|
| <input type="checkbox"/> Bowling             | <input type="checkbox"/> Listening to/making music |
| <input type="checkbox"/> Cooking/baking      | <input type="checkbox"/> Playing games             |
| <input type="checkbox"/> Drawing/painting    | <input type="checkbox"/> Taking walks              |
| <input type="checkbox"/> Going outside       | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Going to the movies | <input type="checkbox"/> Other _____               |

2. What is your favorite thing to watch on TV?

3. What is your favorite food?

4. When you have a problem or a question, who do you talk to?

5. What time do you usually wake up?

6. What time do you usually go to bed?

7. Who do you live with right now?

8. How would you feel about living on your own?

9. How would you feel about living with a roommate?

10. Did someone help you answer these questions?

11. If so, who?

# APPLICATION FOR RENTAL HOUSING

This application is for affordable rental housing located at 257 E. Ridgewood Avenue in Ridgewood, New Jersey.

This project includes 2 licensed group homes and 6 unlicensed independent living apartments for adults with developmental disabilities:

- 4 one-bedroom apartments and
- 2 two-bedroom (shared) apartments

**This application is for the unlicensed independent living apartments ONLY.**

If you are interested in applying for a bedroom in one of the licensed group homes, please contact Angela Fordham Lewis at [angela@fordham-lewisconsulting.org](mailto:angela@fordham-lewisconsulting.org) to learn more about that process.

Applicants for the unlicensed independent living apartments must:

- Be 18 years of age or older
- Be income eligible (maximum allowable annual income is \$38,300)
- Have a developmental disability as certified by a physician
- Be capable of living independently

Rents will range from \$825 to \$1,025 for the one-bedroom apartments and \$1,075 to \$1,275 for the two-bedroom (shared) apartments. The anticipated move-in is late summer.

**For questions or assistance, please contact our Housing Services Coordinator at 201-291-0619 or [housing@bergenunitedway.org](mailto:housing@bergenunitedway.org).**

## Personal Information

Today's Date: \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

How did you hear about this housing opportunity? \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your reason for applying. \_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian/Alternate Contact's Full Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Describe your current living situation.

- I rent       I own       Other

In your own words, describe your level of independence. \_\_\_\_\_  
\_\_\_\_\_

Would you rather:

- Live in a one-bedroom apartment (by yourself)  
 Live in a two-bedroom apartment (with a roommate)

*Ridgewood Supportive Housing includes both one- and two-bedroom apartments. We will take your preferences into consideration; however, apartment selection is based upon multiple factors including careful review of one's application and a person-to-person interview. Roommate pairings are made according to common likes and dislikes as well as schedule.*

What agency, company or private individual is providing you with support services? *Do not include DDD, Medicaid or Social Security.*

Provider's Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

How are services paid for? \_\_\_\_\_

Which daily activities do you participate in?

- Employment
- School
- Volunteering
- Day Program

Do you drive?

- Yes       No

Do you own a car?

- Yes       No

If yes, include details about the vehicle you will park at the apartment.\*

*\*All vehicles must be insured, registered to the tenant, and drivable.*

Make: \_\_\_\_\_

Model: \_\_\_\_\_

Color: \_\_\_\_\_

License Plate Number: \_\_\_\_\_

## Legal Information

**A background check will be conducted on each application. Findings may result in this application being disqualified.**

Do you have any felonies or misdemeanors? If yes, check all that apply.

- Sexual misconduct
- Illegal possession, manufacture, sale and/or distribution of a controlled substance
- Physical crime against a person or persons and/or another person's property

Have you ever been evicted?

- Yes
- No

If yes, please provide the address of the unit from which you were evicted.

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Have you ever filed for bankruptcy?

- Yes
- No

If yes, please describe. \_\_\_\_\_

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## Financial Information

Include your gross monthly amount of income and current documentation for each item. If an item is not applicable, list N/A.

Applicant Name: \_\_\_\_\_

Source of Income*	Gross Monthly Amount
Employment	
Unemployment	
Pension	
Social Security Retirement	
Supplemental Security Income	
Social Security Disability Insurance	
Alimony	
Child Support	
Public Assistance	
Military Pay	
Life Insurance Policy	
Supplemental Trust	
Interest Income	
Dividend Income	
Rental Property	
Other:	
Other:	
<b>Total Monthly Gross Income</b>	

Do you anticipate any changes in income in the next 12 months?

Yes       No

Assets*	Value
Certificates of Deposit	
Credit Union	
Savings Bond	
Life Insurance Policy	
Mutual Funds	
Stocks	
Bonds	
Annuities	
Real Estate	
Other:	
Other:	
<b>Total Value</b>	

Do you have a budget from DDD?

- Yes       No

If yes, please answer the following:

Tier Level: \_\_\_\_\_

Individual Budget Amount: \_\_\_\_\_

Which program?

- Community Care Waiver
- Supports Program
- Self-Directed Services
- Self-Directed Day Program
- Pending

Do you have a Housing Voucher?

- Yes       No

If yes, what type? \_\_\_\_\_



## Certification of Applicants

Please read this section carefully. It is very important.

I/We certify the information given in this application is accurate and complete. I/We further understand that any inaccuracies or information withheld may be the basis for immediate denial of my application by the Owner/Agent. I/We, by signature below, authorize the Owner/Agent to request a complete criminal background check through an outside independent background service company to secure a written report of all information pertaining to [but not limited to] sex offender records, criminal background, etc. I/We further agree that this application does not constitute any oral and/or written commitment on the part of the Owner/Agent. I/We understand the Owner/Agent will request only that information necessary to determine the person's eligibility or level of assistance.

Please be further advised.

Federal law prohibits the Landlord from discrimination against any applicant because of race, color, creed, religion, sex, national origin, political or other affiliation, family status, handicap, or source of income. As required by federal law, applicants must produce proof of their social security numbers. Individuals who have not been assigned a social security number are required to sign and date a certification stating that a social security number has not been assigned. This certification requires subsequent compliance should this apply.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian, if applicable

\_\_\_\_\_  
Date

# AUTHORIZATION FOR RELEASE OF INFORMATION

## **Consent**

I authorized and direct any Federal, State or local agency, organization, business, or individual to release to BCUW/Madeline Housing Partners, LLC any information or material needed to complete and verify my application for tenancy.

I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) or the NJ Department of Community Affairs (DCA) in determining possible rental assistance.

## **Information Covered**

I understand that, depending on the program policies and requirements, previous or current information regarding myself may be needed. Verifications and inquiries that may be requested include, but are not limited to:

Identity and marital status	Employment income and assets
Residences and rental activity	Social Security benefits
Credit and criminal activity	Medical or child care allowances

## **Groups or Individuals That May Be Asked**

The groups or individual(s) that may be asked include, but are not limited to:

Previous landlords	Law enforcement agencies
Schools and/or colleges	Past and present employers
Social Security Administration	Utility companies
Banks and other financial institutions	Social services providers
County Welfare Agencies	

## **Computer Matching Notice and Consent**

I understand and agree that HUD, NJ DCA or Bergen County's United Way and Madeline Housing Partners, LLC may conduct computer matching programs to verify the information supplied for my application or recertification. If a computer match is done, I understand that I have the right to a notification of any adverse information found and an opportunity to disprove incorrect information. HUD or NJ DCA may in the course of its duties exchange such automated information with other Federal, State or local agencies, including but not limited to: State Employment Security Agencies, Department of Defense, Office of Personnel Management, the U.S. Postal Service, The Social Security Administration, and State Welfare and Food Stamp agencies.

## **Conditions**

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 BCUW/Madeline Housing Partners, LLC and will stay in effect for the life of tenancy. I understand that I have the right to review my file and correct any information that I can prove is incorrect.

## **Signature**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

# DISABILITY CERTIFICATION FORM

IDENTIFYING INFORMATION					
Individual's Name:			Date of Birth:		
Last 4 Digits of Social Security Number:					
CIRCLE APPLICABLE CODES					
PRIMARY ICD-9 CODES	ICD-9 CODE	ICD-10 DIAGNOSTIC CODE	PRIMARY ICD-9 CODES	ICD-9 CODE	ICD-10 DIAGNOSTIC CODE
Abetalipoproteinemia	272.5	E78.6	Hallervorden-Spatz Syndrome	333.0	G23.0
Acrocephalosyndactyly (Apert's Syndrome)	755.55	Q87.0	Head Injury, unspecified – Age of onset:	959.01	S09.90XA
Adrenaleukodystrophy	277.86	E71.529	Hemiplegia, unspecified	342.9	G81.90
Arginase Deficiency	270.6	E72.21	Holoprosencephaly	742.2	Q04.2
Agenesis of the Corpus Callosum	742.2	Q04.3	Homocystinuria	270.4	E72.11
Agenesis of Septum Pellucidum	742.2	Q04.3	Huntington's Chorea	333.4	G10
Argyria/Pachygyria/Microgyria	742.2 Or 758.33	Q04.3	Hurler's Syndrome	277.5	E76.01
Aicardi Syndrome	333	G23.8	Hyperammonemia Syndrome	270.6	E72.4
Alcohol Embryo and Fetopathy	760.71	F84.5	I-Cell Disease	272.2	E77.0
Anencephaly	655.0	Q00.0	Idiopathic Torsion Dystonia	333.6	G24.1
Angelman Syndrome	759.89	Q93.5	Incontinentia Pigmenti	757.33	Q82.3
Asperger Syndrome	299.8	F84.5	Infantile Cerebral Palsy, unspecified	343.9	G80.9
Ataxia-Telangiectasia	334.8	G11.3	Intractable Seizure Disorder	345.1	G40.309
Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)	299.0	F84.0	Klinefelter's Syndrome	758.7	Q98.4
Biotinidase Deficiency	277.6	D84.1	Krabbe Disease	333.0	E75.23
Canavan Disease	330.0	E75.29	Kugelberg-Welander Disease	335.11	G12.1
Carpenter Syndrome	759.89	Q87.0	Larsen's Syndrome	755.8	Q74.8
Cerebral Palsy, unspecified	343.69	G80.9	Leigh Disease	330.8	G31.82
Cerebral Palsy, Hemiplegic, Congenital	343.1	G80.2	Lesch-Nyhan Syndrome	277.2	E79.1
Cerebral Palsy, Paraplegic, Congenital	343	G80.1	Lissencephaly	742.2	Q04.3
Cerebral Palsy, Quadriplegic	343.2	G80.0	Lowe (Terrey MacLachlan) Syndrome (Oculocerebrorenal Dystrophy)	270.8	E72.03
Charcot Marie Tooth Disease	356.1	G60.0	Marfan Syndrome	759.82	Q87.40
CHARGE Association	759.89	Q89.8	Megalencephaly	742.4	Q04.5
Cockayne Syndrome	759.89	Q89.8	Menkes Disease (X-Linked)	275.1	E83.09
Coffin-Lowry Syndrome	759.89	Q89.8	Metachromatic Leukodystrophy	330.0	E75.25
Congenital Defects of Glycosylation	279.03	D80.3	Methylmalonic Aciduria (Acidemia)	270.3 or 270.7	E71.120
Cornelia de Lange Syndrome	759.89	Q89.8	Microencephaly	742.1	Q02
Cri-du-chat Syndrome	758.31	Q93.4	Mild Intellectual Disability	317.0	F70
Crouzon Syndrome	756.0	Q75.1	Mixed Conductive and Sensorineural Hearing Loss	389.2	H90.8

# DISABILITY CERTIFICATION FORM

DiGeorge Syndrome	279.11	D82.1	Moderate Intellectual Disability	318.0	F71
Down Syndrome	758.0	Q90.9	Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.1	H54.10
Dubowitz Syndrome	742.8	Q07.8	Mucopolipidosis Type IV	330.1	E75.11
Duchenne Muscular Dystrophy	359.1	G71.0	Mucopolysaccharidosis (Hunter's Syndrome, Hurler's Syndrome, Scheie's Syndrome)	277.5	E76.01
Dystonia Musculorum Deformans	333.6	G24.1	Multiple Sclerosis	340	G35-37
Encephalopathy, not elsewhere classified	348.3	G93.40	Neuroaxonal Dystrophy	333	G23.0
Epilepsy, unspecified	345.9	G40.90	Neurofibromatosis (von Recklinghausen's Disease)	237.71	Q85.01
Fetal Alcohol Syndrome	760.71	Q86.0	Neuronal Heterotopia	742.8	Q07.8
Fragile X Syndrome	759.83	Q99.2	Niemann-Pick Disease	272.7	E75.249
Friedreich's Ataxia	334.0	G11.1	Noonan Syndrome	759.81	Q87.1
Fucosidosis	271.8	E77.1	Other Cerebral Degeneration	331.8 Or 349.89	G32.89 Nonspecified
Gaucher's Disease	272.7	E75.22	Other Chromosomal Abnormalities, not elsewhere classified	758.89	Q99.8
Generalized Convulsive Epilepsy	345.1	G40.309	Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)	277.2	E79.1
Generalized Non-Convulsive Epilepsy	345.0	G40.401	Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)	759.9	Q87.1
Gonadal Dysgenesis (Turner's Syndrome)	758.6	Q96.9	Other Specified Anomalies of Nervous System (Familial Dysautonomia; Riley-Day Syndrome)	742.8	G90.1
Grand Mal Status	345.3	G40.409	Other Specified Cerebral Degenerations in Childhood (Alper's Disease or Gray-Matter Degeneration; Infantile Necrotizing Encephalomyelopathy; Leigh's Disease; Subacute Necrotizing Encephalopathy or Encephalomyelopathy, Rett's Syndrome)	330.8	G31.81
Other Spinocerebellar Diseases (Ataxia- Telangiectasia [Louis-Bar Syndrome])	334.8	G11.3	Other Specified Pervasive Developmental Disorders (Asperger's Disorder, Atypical Childhood Psychosis; Borderline Psychosis of Childhood)	299.8	F84.5
Paraplegia (Paralysis of Both Lower Limbs)	344.1	G82.20	Spina Bifida without mention of Hydrocephalus	741.9	Q05.8
Partial Epilepsy, with Impairment of Consciousness (Psychomotor Epilepsy)	345.4	G40.201	Spinal Cord Injury (Initial Encounter)	952.9	S14.109A

# DISABILITY CERTIFICATION FORM

Patau's Syndrome	758.1	Q91.7	Spinal Muscular Atrophy, Unspecified	335.1	G12.1
Pervasive Developmental Disorder-NOS	299.9	F84.9	Sturge-Weber Syndrome	759.6	Q85.8
Pick's Disease	331.11	G31.01	Symptomatic Torsion Dystonia (Athetoid Cerebral Palsy)	333.7	G80.3
Propionic Acidemia	270.3	E71.121	Tay-Sachs Disease	330.1	E75.02
Prader-Willi syndrome	759.81	Q87.1	Torch Syndrome	760.02	P00.2
Profound Intellectual Disability	318.2	F73	Trisomy 13	758.1	Q91.13
Pyruvate Dehydrogenase Deficiency (lactic, pyruvic)	271.8	E74.4	Trisomy 18 (Edwards' Syndrome)	758.2	Q91.3
Quadriplegia and Quadripareisis	344.00	G82.5	Tuberous Sclerosis	759.5	Q85.1
Refsum's Disease	356.3	G60.1	Unspecified (Traumatic Blindness NOS)	950.9	S04.019A
Rett's Syndrome	330.8	F84.2	Unspecified Anomaly of Brain, Spinal Cord and Nervous System	742.9	Q07.9
Rubinstien-Taybi Syndrome	759.89	Q87.2	Unspecified Cause of Encephalitis	323.9	G04.90
Sandhoff Disease	330.1	E75.01	Unspecified Delay in Development (Developmental Disorder NOS)	315.9	F89
Sanfillippo Syndrome	277.5	E76.22	Unspecified Disease of Spinal Cord	336.9	G95.9
Schindler Disease Type 1	271.8	E77.1	Unspecified Intellectual Disability	319	F79
Schizencephaly	742.4	Q04.6	Unspecified Pervasive Developmental Disorder (Pervasive Developmental Disorder NOS)	299.9	F84.9
Seckel Syndrome	759.89	Q87.1	Untreated Phenylketonuria	270.1	E70.0
Septo-optic Dysplasia	742.4	Q04.4	Urea Cycle Defects	270.6	E72.20
Severe Hypoxic Ischemic CNS Injury	768.73	P91.63	Usher Syndrome Type II	694.4	L10.4
Severe Intellectual Disability	318.1	F72	Vater Association	759.89	Q87.2
Sjogren-Larsson Syndrome	757.1	Q80.9	Werdnig-Hoffman	335.0	G12.0
Spastic Hemiplegia	342.1	G80.2	Williams-Beuren Syndrome	758.9	Q87.8
Spielmeyer-Vogt Disease	330.1	E75.4	Wilson Disease	275.1	E83.01
Spina Bifida	741	Q05	Zellwager Syndrome	277.86	E71.510
			Psychiatric Disorder or Problem		F99

# DISABILITY CERTIFICATION FORM

My signature on this document certifies that the diagnosis identified is based on medical evaluation and documentation and/or established medical evaluation and documentation.

Physician's Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_