

**HELPING PEOPLE ACHIEVE ECONOMIC SECURITY FOR  
OVER 40 YEARS**

- \_\_\_\_\_ **East Hills Senior Housing**
- \_\_\_\_\_ **General Housing**
- \_\_\_\_\_ **Shelter Plus Care**
- \_\_\_\_\_ **FEMA**
- \_\_\_\_\_ **Lend A Hand**



Office Use: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**Opportunities  
for Broome Inc.**

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

**OFB APPLICATION FOR SERVICES**

FULL FIRST NAME :		FULL MIDDLE NAME:		FULL LAST NAME:		
STREET ADDRESS:		VILLAGE, CITY OR TOWN:			STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:	E-MAIL ADDRESS:		REFERRAL SOURCE:	

**PLEASE TELL US WHY YOU ARE APPLYING FOR SERVICES TODAY:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BEGINNING WITH YOURSELF, PLEASE FILL IN ALL THE SPACES BELOW FOR ALL MEMBERS OF YOUR HOUSEHOLD WHO ARE APPLYING FOR OFB ASSISTANCE.

Have you or anyone in your home ever received services for OFB (yes or no)? \_\_\_\_\_

If "Yes" please list the services and dates of service: \_\_\_\_\_

NAME	SEX M\F	AGE	DATE OF BIRTH	RELATIONSHI P	SOCIAL SECURITY NUMBER	DISABLE D Yes or No	CURRENT STATUS Example: Employed, Unemployed, Student, etc.	Highest Grade Level Completed
1.				SELF				
2.								
3.								
4.								
5.								
6.								
7.								

PLEASE MARK THE BOXES BELOW YES OR NO:

ARE YOU HISPANIC OR LATIN? ( ) YES ( ) NO	ARE YOU A VETERAN? ( ) YES ( ) NO	DO YOU HAVE HEALTH INSURANCE? ( ) YES ( ) NO	DO YOU RECEIVE MEDICAID? ( ) YES ( ) NO	DO YOU RECEIVE MEDICARE? ( ) YES ( ) NO
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PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES YOUR FAMILY TYPE:

( ) SINGLE FEMALE HEAD OF HOUSEHOLD w\CHILDREN	( ) SINGLE MALE HEAD OF HOUSEHOLD w\CHILDREN	( ) TWO PARENT HOUSEHOLD w\CHILDREN	( ) SINGLE PERSON	( ) TWO ADULTS WITH NO CHILDREN	( ) OTHER (PLEASE SPECIFY):
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PLEASE LIST ALL FAMILY MEMBERS WHO HAVE A SOURCE OF INCOME ON LINE A. PLEASE LIST THEIR MONTHLY INCOME FROM EACH SOURCE ON LINES 1 THRU 9 UNDER THEIR NAMES. DO NOT TOTAL THE LINES OR COLUMNS.

SOURCES OF INCOME	YOUR NAME HERE	NAME OF FAMILY MEMBER HERE	NAME OF FAMILY MEMBER HERE	NAME OF FAMILY MEMBER HERE
PRINT NAMES HERE →				
1. TANF (DSS)	\$	\$	\$	\$

2. SSI\SSD	\$	\$	\$	\$
3. SOCIAL SECURITY	\$	\$	\$	\$
4. PENSION / BENEFITS	\$	\$	\$	\$
5. SAFETY NET ASSISTANCE	\$	\$	\$	\$
6. UNEMPLOYMENT INSURANCE	\$	\$	\$	\$
7. EMPLOYMENT(GROSS SALARY)	\$	\$	\$	\$
8. OTHER SOURCES OF INCOME	\$	\$	\$	\$
<b>TOTAL</b>				

**IF YOU DO RECEIVE ANY BENEFITS, PLEASE CHECK AND THEN PLEASE LIST MONTHLY AMOUNT NEXT TO THE \$ SIGN:**

( ) SECTION 8 RENTAL ASSISTANCE? \$	( ) WOMEN, INFANTS, AND CHILDREN (WIC)? \$	( ) RENT FROM YOUR RENTAL PROPERTIES? \$	( ) RENT FROM BOARDERS? \$	( ) ALIMONY \$	( ) DISABILITY OR WORKERS COMPENSATION? \$
( ) UTILITY VOUCHER? \$	( ) PUBLIC HOUSING? \$	( ) FOOD STAMPS? \$	( ) VETERANS BENEFITS? \$	( ) CHILD SUPPORT? \$	( ) PAYMENTS FROM A TRUST? \$

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

ARE YOU AN AMERICAN CITIZEN? ( ) YES ( ) NO	IF NO, DO YOU HAVE REFUGEE STATUS? ( ) YES ( ) NO ( ) N/A	IF NO, ARE YOU A QUALIFIED ALIEN? ( ) YES ( ) NO ( ) N/A	ARE YOU CURRENTLY ON PROBATION? ( ) YES ( ) NO	ARE YOU CURRENTLY ON PAROLE? ( ) YES ( ) NO
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**PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES YOUR RACE:**

( ) BLACK OR AFRICAN-AMERICAN	( ) WHITE	( ) ASIAN	( ) NATIVE-AMERICAN OR ALASKAN NATIVE	( ) MULTI-RACIAL	( ) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	( ) OTHER
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**APPLICANT'S BIRTH NAME OR ANY OTHER NAME (ALIASES) YOU MAY HAVE USED IN THE PAST, IF ANY:**

<b>FIRST:</b>	<b>LAST:</b>	<b>MI:</b>
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**CERTIFICATION: I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ON THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN ADDITION, I HEREBY AUTHORIZE OFB SERVICES TO VERIFY ANY STATEMENTS I HAVE MADE ON THIS APPLICATION. I UNDERSTAND THAT I MAY BE REQUIRED TO DOCUMENT THE INFORMATION ABOUT MY SOURCES OF INCOME LISTED ON THIS APPLICATION. I AGREE THAT THIS APPLICATION SHALL REMAIN THE PROPERTY OF OFB.**

\_\_\_\_\_  
PLEASE PRINT YOUR NAME HERE

\_\_\_\_\_  
PLEASE SIGN YOUR NAME HERE

\_\_\_\_\_  
ENTER TODAY'S DATE HERE



<p><b>DOES YOUR PAYMENT INCLUDE UTILITIES? ( ) YES ( ) NO</b>  <b>If not what do you pay for?</b>  <input type="checkbox"/> ELECTRIC    <input type="checkbox"/> GAS    <input type="checkbox"/> OIL    <input type="checkbox"/> PROPANE    <input type="checkbox"/> WATER    <input type="checkbox"/> SEWER    <input type="checkbox"/> OTHER (please specify):</p>
<p><b>DO YOU CURRENTLY LIVE IN PUBLIC HOUSING? ( ) YES ( ) NO</b></p>
<p><b>HAVE YOU EVER BEEN CONVICTED OF A FELONY? ( ) YES ( ) NO</b>  <b>If YES, please explain:</b> _____          _____</p>
<p><b>DO YOU RECEIVE RENTAL ASSISTANCE FROM ANY OTHER SOURCE? ( ) YES ( ) NO</b></p>
<p><b>ARE YOU CURRENTLY EMPLOYED? ( ) YES ( ) NO</b>  <b>If Yes, What is your position?</b>  <b>Where do you work?</b>  <b>How long have you been employed there?</b></p>
<p><b>HAVE YOU RESIDED IN A RESIDENCE THAT HAS HAD BED BUGS WITHIN THE LAST 2 YEARS? ( ) YES ( ) NO</b>  <b>If Yes, When?</b>  <b>Date of extermination?</b></p>

**REFERENCES: We require three (3) references not related to you.**

**Name:** \_\_\_\_\_

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

**Phone Number (s):** \_\_\_\_\_

**Years Known:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_

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

**Phone Number (s):** \_\_\_\_\_

**Years Known:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_

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

**Phone Number (s):** \_\_\_\_\_

**Years Known:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_