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EQUAL HOUSING OPPORTUNITY

SECTION 8 HOUSING – HOUSING FOR THE ELDERLY OR ELDERLY HANDICAPPED
and
ASSISTED LIVING PROGRAM (ALP) – RESIDENTIAL ENRICHED HOUSING PROJECT

☐	Please check here if you are interested in the **Assisted Living Program (ALP)**, see page eight (8) for more information.

Send by regular mail or drop off only one (1) application per family. Do not send by registered or certified mail. Applications will be accepted beginning March 6, 2024, and must be received by or postmarked no later than March 26, 2024.

If you require a reasonable accommodation to submit this application, please contact Yaritza Mercado at (718) 366-3800 or ymercado@riseboro.org.

MAIL TO OR DROP OFF : Moffat Gardens Senior Houses
22 Moffat St, Management Office
Brooklyn, NY 11207

All questions below must be answered. If a question does not apply to you, write "N/A." Each application received will be logged. Since so many senior citizens need housing, this development will not be able to accommodate all who are eligible. As qualified applicants can be reached, they will be informed of an interview. The head of household **must be 62 years of age or older**.
Please be sure to sign the application. Photocopies of this application will not be accepted.

No payment or fee should be given to anyone in connection with the preparation, processing, or filing of this application for Section 8 Housing.

THE MAXIMUM ALLOWABLE OCCUPANTS FOR A ONE (1) BEDROOM APARTMENT IS TWO (2) OCCUPANTS.

This information is to be filled out by the applicant(s):

Head of Household Name:_____

Current Address:_____Apt #_____

City:_____State:_____Zip Code:_____

Home Phone No. (____)_____ Cell Phone No. (____)_____

FAMILY COMPOSITION:

How many persons are in your household? _____

How many bedrooms do you have now? _____

List all persons who will live with you in this Section 8 development, begin with yourself.

Full Name	Relationship	Birthdate	Age	Gender	Occupation*
_____	Head of Household	_____	___	_____	_____
_____	_____	_____	___	_____	_____

*If retired, write “retired” for occupation

FUNCTIONAL STATUS:

Do you or any member of your family require an accommodation(s)? YES ___ NO___

If “YES” which member(s) of your household? _____

Do you or any member of your household require a wheelchair, walker, crutches, metal braces, cane, or any type of mechanical aid to assist in walking or otherwise live with a mobility impairment? YES ___ NO___

If “YES” which member(s) of your household? _____

INCOME:

List all full and/or part-time employment for all household members. Included self-employed earnings.

Household Member	Employer’s Name & Address	Gross Earnings
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

OTHER SOURCES OF INCOME:

Examples include Welfare, Social Security, SSI, Pension, Disability Compensation, Interest, Baby Sitting, Foster Care, Care-taking, Alimony, Child Support, Annuities, Dividends, Income from Rental of Property, Armed Forces Reserves, Scholarships, Unemployment Compensation, and Grants.

Household Member	Type of Income	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

CURRENT ASSETS:

Checking Accounts

Name of Bank:_____Acct. No._____Balance $_____

Name of Bank:_____Acct No._____Balance $_____

Savings Accounts

Name of Bank:_____Acct. No._____Balance $_____

Name of Bank:_____Acct. No._____Balance $_____

Certificates of Deposit or Savings Certificates

Name of Bank:_____Acct. No._____Balance $_____

Name of Bank:_____Acct. No._____Balance $_____

Stocks & Bonds (value) $_____ War Bonds (value) $_____

Life Insurance (value) $_____ Pension (value) $_____

Real Estate

Do you own real estate? YES ___ NO___ If “YES” what is the current value? $_____

RECENTLY DISPOSED ASSETS:

Have you or anyone who will be living with you disposed of any assets for less than fair market value, during the past two (2) years?

If “YES” provide the following information:

Type of Asset (Include gifts)	Asset’s Market Value At time of Disposition	Date of Disposition	Amount Received
_____	$_____	_____	$_____
_____	$_____	_____	$_____

MEDICAL EXPENSES:

Consider only medical expenses that **WILL NOT** be paid or reimbursed by an outside source such as insurance, medicare, or grants by a government agency or charitable organization.

What are the medical expenses **anticipated** to be paid by your household in the coming 12-month period?

$_____

HANDICAPPED EXPENSES:

This allowance applies only if a family member is Handicapped or Disabled. Consider only handicap expenses that **WILL NOT** be paid or reimbursed by an outside source such as insurance, Medicare, or grants by a government agency or charitable organization.

What are the medical expenses **anticipated** to be paid by your household in the coming 12-month period?

$_____

DO YOU CURRENTLY LIVE IN PUBLIC HOUSING OR FEDERALLY ASISTED HOUSING?

YES ___ NO___

If “YES” enter the Name of Project: _____

Address of the Project: _____

Phone No. of the Project Manager: _____

DO YOU CURRENTLY HAVE SECTION 8? YES ___ NO___

If "YES" enter the Building Address: _____

Name of the Landlord: _____

Phone No. of the Landlord: _____

INVOLUNTARY DISPLACEMENT:

If you have experienced involuntarily displacement due to any of the reasons listed below, please check all that apply.

____ A disaster, such as fire or flood, has made the unit uninhabitable
____ The unit or building is undergoing code enforcement activities by a government agency
____ The project owner has taken an action which resulted in you having to vacate the unit*

*If yes, check one of the three reasons below
____ The action was due to late, non- or under-payment of rents due
____ The action was beyond your control
____ Other

Please describe the action: _____
_____
_____
_____
_____
_____

Are you vacating or have you vacated the unit as a result of actual or threatened physical violence against one or more family members or do you live in a unit with an individual who engages in such violence?

YES ___ NO___

PAYING MORE THAN 50 PERCENT OF INCOME FOR RENT:

Are you paying more than fifty percent (50%) of your gross monthly income for rent and for utilities? YES ___ NO___

What is your monthly rent under current lease agreement? $_____

What is your average monthly utilities for the past year? $_____

Check the utilities currently paid by you and indicate the amount:

___Gas $_____, ___Electric $_____, ___Heat $_____, ___Water $_____

SUBSTANDARD HOUSING:

Check all of the following that describes your current housing.

_____ is dilapidated (endangers the health, safety, or well being of the family)
_____ does not have operable indoor plumbing
_____ does not have a usable flush toilet for the exclusive use of the family
_____ does not have a usable bathtub/shower for the exclusive use of the family
_____ does not have electricity, or has inadequate or unsafe electrical service
_____ does not have a safe or an adequate source of heat
_____ should, but does not have a kitchen
_____ has been declared unfit for habitation by an agency or unit of government
_____ neighborhood conditions that are detrimental or hazardous to the health, safety and well being of the applicant, such as crime, drugs, etc.

Any applicant who is a “homeless family” meets the criteria of substandard housing. A “homeless family” is defined as any individual or family who lacks a fixed, regular and adequate nighttime residence and has a primary nighttime residence that is:

_____ living in a place not meant for human habitation
_____ living in emergency shelter
_____ living in transitional housing
_____ exiting an institution where they temporarily resided

PROGRAM INFORMATION:

How did you hear about this development? Check all that apply.

Posted Sign or Flyer _____ Newspaper Ad _____ Local Organization or Church _____

Friend or family _____ Section 8 Housing List _____ Social Media Post _____ Radio Ad _____

RiseBoro Community Partnership _____ Other _____

22 MOFFAT STREET
SIGNATURE PAGE

I DECLARE THAT THE STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. WARNING: WILLFUL OR FALSE STATEMENTS OR INFORMATION OR MISREPRESENTATION ARE A CRIMINAL OFFENSE UNDER SECTION 1001 OF TITLE 18 OF THE U.S. CODE.

_____ _____
Head of Household Signature — Date

_____ _____
Member of Household Signature — Date

DO NOT MAIL MORE THAN ONE APPLICATION PER FAMILY PER BUILDING. IF MORE THAN ONE APPLICATION IS RECEIVED PER BUILDING, IT WILL BE DROPPED TO THE BOTTOM OF THE WAITLIST.

NOTE: APPLICATION <u>MUST</u> BE SIGNED

Assisted Living Program

RiseBoro Community Partnership is pleased to announce the Moffat Gardens Assisted Living Program at Moffat Gardens Senior Houses. This exciting, Medicaid-funded program will be available in twenty-six units at Moffat Gardens Senior Houses.

The Assisted Living Program is a residential Enriched Housing Program administered by the New York State Department of Health. Through this program, residents receive room, board and supportive services (home care).

Eligibility

Eligibility for the ALP units is based on both the Section 8 Federal Guidelines and medical screening and review conducted by a medical professional. The ideal ALP resident is a frail elderly person who is able to live independently and meets the following criteria:

1. Does not require continual nursing or medical care;
2. Is not chronically bedfast (is able to get out of bed) or chairfast (is not dependent on a wheelchair), and does not require lifting or two-person transfer; and
3. Is not impaired cognitively (mental state), physically (physical state) or medically (requires intensive medicinal treatment) to the point that they are potentially a danger to themselves or others.

Services

The MG ALP residents will live in apartment units with a full bath and kitchen, with access to a common seating area on each floor and staff office. Residents will be served 3 congregate meals daily in the dining room. There will be 24-hour access to home attendant services if needed in addition to appointments with physical and occupational therapists and nutritional guidance. Residents will also have access to light housekeeping and laundry services.

There will be dedicated daily activities planned by a staff member that will include discussion groups, movies, educational workshops, games, health screenings, trips, family visiting hours and access to the art classes and Tai Chi that our current residents enjoy. In addition, the program will offer case management services.

Cost

The MG ALP program is funded through SSI and Medicaid. SSI covers the tenant’s room and board (rent, food, housekeeping and laundry) and Medicaid pays for home attendant services, Physical Therapy, Occupational Therapy and Dietary management. Most of an ALP’s resident’s monthly SSI payment (minus a monthly personal allotment) will go towards the monthly rate for the ALP Program. However, the monetary value of the services greatly exceeds the actual out of pocket cost, which are far less than one would pay in a private-pay for profit facility.

Application

If you are interested in being considered for an ALP unit at Moffat Gardens, please check the box at the top of Page 1 of this application. Please note that checking this box WILL NOT affect your application to Moffat Gardens Senior Houses. If a non-ALP unit becomes available to you before an ALP unit, you will be considered for the non-ALP unit.