



**Southwest Florida Affordable Housing Choice
Foundation, Inc.**
4224 Renaissance Preserve Way
Fort Myers, FL 33916
Phone (239) 344-3220

For Office Use Only: Date Received: _____ Time: _____ Received By: _____

PRE-APPLICATION

Applicant Name: _____ Total number of people who will be living in the unit? _____

Street Address: _____ E-Mail Address: _____

City, State, Zip: _____ Day Phone #: _____

(CIRCLE all that apply) RACE: 1. White 2. Black 3. American Indian/Alaska Native 4. Asian 5. Native Hawaiian/Pacific Islander **Hispanic :** Yes or No

Does head of household, spouse or co-head have legal immigration status? YES _____ NO _____

Have you ever received or are you now receiving housing assistance? YES _____ NO _____

List the Names of ALL household members that will occupy the unit. Indicate head of household first:

Household Member (and relationship)	Sex	Social Security Number	Date of Birth	Marital Status	Monthly Gross Income	Source of Income (Indicate Soc Sec, employment, VA)
<i>(Head)</i>						

PREFERENCE: VETERAN STATUS

Yes No

Have you been discharged or released from active duty in the Armed Forces under Honorable conditions?

Yes No

Are you a Veteran, spouse of a deceased Veteran and remain unmarried or related to a deceased Veteran who was an immediate family member at the time of death (children, dependent)?

Yes No

Is the Veteran permanently absent from the household, but legally responsible for the support of one or more family member and the spouse is not remarried

REASONABLE ACCOMODATIONS - OPTIONAL QUESTIONS:

Answering the following questions is optional. However, if you decline to answer, we may be unable to determine if you qualify for a Reasonable Accommodation or if you are eligible for a special unit for a person with mobility impairment or other impairment.

1: Do you or any member of your household have a condition that requires: **(circle all that apply)**
Communication in a specially requested formant because of a disability
Separate bedroom
unit for hearing impaired
Other physical modification
Unit for vision impaired
Wheelchair accessible unit
Name of household member requiring the items circled above: _____

If you circled any of the above, please explain exactly what you will need in the unit, other services of type of communications (example: send all mail in audible format, large print or email).

2: Do you or any household member need assistance to go up or down stairs?
 Yes No If yes, explain: _____
Name of household member requiring assistance: _____

3: Will you or any household member require a Live-in-Aide to assist you?
 Yes No If yes, explain: _____
Name of household member requiring assistance: _____

4: Are there any other accommodations which you or anyone in the household will need to fully utilize the SWFAHCF programs and services?
If yes, explain: _____

I do hereby certify all information is complete and true.

In order to process this application, a signature from the Head and Co-Head (if applicable) and all members 18 years and older are required. If signatures are missing, the application will be considered incomplete and will not be considered.

Head of Household Client Signature Print Name Date

Co-Head or other Adult Family Member Signature Print Name Date

Other Adult Family Member Signature Print Name Date

Signature of any person who assisted in filling out this application

