



Non-refundable application fee of \$40 per applicant (cash or money order only accepted). Must return with a copy of Driver's License, S.S. Card and 3 most recent pay stubs. Incomplete applications will not be accepted.

**\*APPLICATION MUST BE HANDED IN PERSON ONLY\***

## RENTAL APPLICATION & TENANT RELEASE FORM

THE INFORMATION ON THIS PAGE IS TO BE COMPLETED BY THE PROSPECTIVE TENANT FOR THE PURPOSE OF OBTAINING A RENTAL LEASE.

*Residency can be denied on the basis of unsatisfactory review of employment verification, personal references, insufficient or prior landlord references, insufficient history of paying rent or employment, medical certification, or any other personal information revealed by the applicant or our due diligence. We do not discriminate on the basis of age, race, religion, national origin or sexual orientation. All residents must be capable of living independently and must not rely upon others for their care, hygiene, feeding, or medication. Any misrepresentation on this application can be grounds for termination of tenancy.*

DATE: \_\_\_\_\_ SUBJECT BUILDING: \_\_\_\_\_ RENT: \_\_\_\_\_ ANTICIPATED MOVE IN DATE: \_\_\_\_\_

APPLICANT NAME-FIRST, MIDDLE, LAST \_\_\_\_\_ BIRTH DATE MM/DD/YEAR \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

DRIVER LICENSE # \_\_\_\_\_ SOCIAL SECURITY CARD \_\_\_\_\_ EMAIL \_\_\_\_\_

CURRENT LANDLORD'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PREVIOUS ADDRESS (IF LESS THAN 2 YEARS): \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PREVIOUS LANDLORD'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

### APPLICANT'S EMPLOYMENT INFORMATION:

NAME: \_\_\_\_\_ ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ PHONE NO \_\_\_\_\_ EMPLOYED SINCE \_\_\_\_\_ WEEKLY SALARY \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

GROSS HOUSEHOLD MONTHLY INCOME: \_\_\_\_\_

HAVE YOU EVER FILED FOR BANKRUPTCY? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES LIST THE STATE AND THE DATE FILED: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF ANY CRIME? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES LIST THE STATE AND NATURE OF THE OCCURRENCE: \_\_\_\_\_

HAVE YOU EVER BEEN TAKEN TO LANDLORD/ TENANT COURT? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES PLEASE EXPLAIN? \_\_\_\_\_

*I hereby grant Garden State Realty Management and/or its designee the right to process this credit application at this time or any other time in the future we deem necessary for the purpose of obtaining a rental lease and or collecting a debt. In compliance with the FAIR CREDIT REPORTING ACT, this notice is to inform you that the processing of this application includes but is not limited to making inquiries deemed necessary to verify the accuracy of the information herein, including procuring consumer reports from consumer reporting agencies, obtaining credit information from other credit institutions and criminal background checks from appropriate law enforcement agencies. You have the right to make a written request within a reasonable period of time to receive additional information. This application and documentation supplied shall remain the property of the landlord regardless if rental lease is granted.*

DATE: \_\_\_\_\_ APPLICANT SIGNATURE: \_\_\_\_\_

**For Rooming house applicants Only!**

Next Of Kin, Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

*If over age 62, please provide the following:*

Personal Physician Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

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

**In the last 12 months (or are you currently) institutionalized and/or under medical care, rehabilitation program, anger management program, clinical study, clinician, or 12-step program [ ] YES [ ] NO**

Please describe: \_\_\_\_\_

**Do you receive or require continuing in-home care, supervision, or monitoring [ ] YES [ ] NO**

Please describe: \_\_\_\_\_

Physician/Program Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Contact \_\_\_\_\_

Care Agency Monitor \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Contact \_\_\_\_\_

**THIS HOUSE IS NOT A LICENSED CARE FACILITY. Under N.J.A.C. 5:27-3.5(a) and 5:27-8.1(b)1, we may require medical certification from a licensed physician to determine whether your residency is appropriate at this location. We may ask your medical history, what medications you take, what services you require, how frequently you need these services, and any other information deemed necessary to confirm that you are not in need of a higher level of care than we can provide under our license. By signing below, you authorize the release of all medical information necessary to determine appropriateness of placement.**