Walden Point
Affordable Assisted Living

Dear Prospective Resident:

Enclosed please find your application packet for Walden Point. Your packet includes the following forms:

1. Walden Point Application for Housing (7 pages, sign page 7)
2. Authorization for Release of Information
3. Authorization for Release of Information to BrightStar of Central Iowa
4. Authorization for Release of Information to Walden Point
5. Authorization for Release of Information to HyVee Incorporated
6. Authorization for Release of Information to Dovetail Services
7. Authorization for Release of Information to BrightStar of Central Iowa for protected Health Information
8. Social Security proof of income (annual benefit statement or award letter or call (800)-772-1213 to request a copy sent to you)
9. Application Fee (include $20)
10. Nurse Evaluation Fee $75 due to BrightStar of Central Iowa at time of pre-evaluation determining eligibility

Completed applications will be put on the waiting list in the order in which they are received or in order of date of move in, if date for move in is not as soon as possible. When your name comes up for occupancy, we will contact you to verify your continued interest in residency and to begin the process.

If your application is older than 90 days when your name comes up for occupancy, we will ask you to complete a new application. After we review your new application packet, we will assist you in applying for other subsidies for which you may qualify. The information contained in your application packet will help us guide you to possible sources for financial and other assistance.

Within thirty days of the day you plan to move into Walden Point you will need to participate in a comprehensive needs assessment provided by BrightStar of Central Iowa in order to establish your individualized service plan. When possible the preliminary needs assessment will take place in your home.

We look forward to welcoming you to Walden Point. If you have any questions, please do not hesitate to contact us.

Sincerely yours,
Christine Vasquez, Administrator

1200 Fourth Street ▪ Des Moines, Iowa 50314
Phone (515) 288-9985 Fax (515) 288-4631

WALDEN POINT
APPLICATION FOR HOUSING
Equal Housing Opportunity

Date Received: _____

This application must be completed and returned with a $20 non-refundable application processing fee. Also enclose copies of social security cards and social security award letter for all applicants.

Applicant Name:
_____
Last MI First

Co-Applicant Name:
_____
Last MI First

Current Address:
_____

City: _____ State: _____ Zip Code: _____
Telephone #: _____

All co-applicants, other than spouse, are required to complete a separate application.

Any applicant who purposefully falsifies, misrepresents or withholds any information related to program eligibility or submits inaccurate and/or incomplete information on this application will not be considered for housing nor placed on the waiting list.

HOUSEHOLD COMPOSITION

List the Head of Household (applicant) and all other persons who will be living in your apartment. Give the relationship of each household member to the head.

Member Full Name	Relationship	Date of Birth	Age	Sex	Student Y or N	Social Security #
	HEAD					

All family members listed as Full Time Students above must provide the following information:

Do you or your spouse anticipate becoming a full-time student in the next 12 months?
_____Yes _____ No If so, please list the school name and address.

School Name & Address:_____

QUESTIONS – Please answer <u>all</u> of the following questions
<u>Use back for extra space</u>

- Marital Status: Married ____ Single____ Widowed____Divorced ____ Separated___
- Disability Status: Disabled____ Non-Disabled____ I choose not to disclose____
- Race: White/Caucasian____ Black/African American____ Asian____ American Indian/Alaskan Native____ Native Hawaiian/Other Pacific Islander____ I choose not to disclose ____
- Ethnicity: Hispanic____ Non-Hispanic____ I choose not to disclose____
- Are you or your spouse a Veteran? Yes No
  If yes, explain:_____
- Does your household have any needs that might be better served by an apartment that is accessible to persons with mobility impairments? Yes No
  If yes, explain: _____
- Have you or anyone named on this application ever been convicted of a crime other than a simple misdemeanor (i.e, traffic ticket, etc)? Yes No
  If yes, explain _____
- Have you ever been evicted? _____ If so, explain _____
- Have you ever received a written notice for nonpayment of rent? Yes No
  If yes, explain _____
- Does your household have a pet?_____
- Do you receive Housing Assistance (HRA Section 8 Certificate or Voucher_____or RAFS _____Other _____)? Yes No
- Are you currently receiving any type of services in your home? Yes No
  If yes, explain_____
- Are you currently on Medicaid (Title 19) or Elderly Waiver? Yes No
- Is there anyone currently living with you that is not on this application? Yes No
  If yes, explain_____
- How did you select our community? Drive by _____ Referral _____
  Newspaper _____ Service Provider _____ Hospital _____Other _____

CURRENT HOUSING STATUS

Do you currently own or rent? (Please circle) Own Rent

Address	City	State	Zip

If you currently rent please complete the following information:

Name of Landlord: _____Tel #:_____
Address: _____
How long have you resided at your current address?_____ Rent $_____/mo.

PREVIOUS HOUSING STATUS

If you have not lived at your current place of residence for at least five years, then please complete the following information:

Previous Address	City	State	Zip

Name of Landlord:_____Tel #: _____
Address: _____
How long did you reside at this address? _____ Rent $_____/mo.

PREVIOUS HOUSING STATUS

Previous Address	City	State	Zip

Name of Landlord:_____Tel #: _____
Address: _____
How long did you reside at this address? _____ Rent $_____/mo.

HOUSEHOLD INCOME INFORMATION
All information will be verified by a third party.
Please check "YES" or "NO" for every question.

List current and anticipated income for the 12-month period commencing or anticipated from the date of occupancy for you and your spouse combined. Include all full time, part time or seasonal employment. If a household member has more than one source of income, use a separate line for each source.

	DO YOU RECEIVE OR EXPECT TO RECEIVE	YES	NO	MONTH
1	Wages, salaries (includes overtime, tips, bonuses)			$
2	Does any member work for someone who pays him/her cash?			$
3	Regular pay for a member of the armed forces?			$
4	Welfare or disability benefits (SSI, SSDI)?			$
5	Worker's Compensation?			$
6	Unemployment benefits or Severance pay?			$
7	Child Support?			$
8	Alimony?			$
9	Education grants, scholarships or VA student benefits?			$
10	Social Security Payments?			$
11	Pensions (PERA, TIAA-CREFF, railroad, etc.)?			$
12	Death Benefits?			$
13	Retirement Benefits?			$
14	Annuities or life insurance dividends?			$
15	Lump sum payments (include inheritance, insurance)			$
16	Net income from rental property?			$
17	Regular cash contributions or gifts from individuals not living			$
18	Other, (list)?			$

For the sources of income in the previous table that you checked "YES", please complete the following table:

Question # from above	Family Member	SOURCE(S) OF INCOME **NAMES AND ADDRESSES AND PHONE NUMBERS** (i.e. employers, public assistance office, social security, pension fund, etc.)

If you need additional space please list on the back of this page. Failure to provide the name, address and phone number for each source of income will delay the processing of your application.

HOUSEHOLD ASSETS
All information will be verified by a third party.
Please check "YES" or "NO" for each item.

	DO YOU HAVE MONEY HELD IN	YES	NO	AMOUNT
1	Checking Accounts			$
2	Savings Accounts			$
3	Stocks			$
4	Capital Investments			$
5	Bonds			$
6	Trusts			$
7	Securities			$
8	IRA/KEOGH Accounts			$
9	Certificates of Deposit			$
10	Pension/Retirement Funds			$
11	Mutual Funds			$
12	Treasury Bills			$
13	Safety Deposit Box			$
14	Insurance Settlement			$
15	Cash Value of Life Insurance Policy (whole life or universal)			$
16	Other (list)			$
				$
		YES	NO	VALUE
17	Do you currently hold a contract for deed?			$
18	Do you currently own real estate? (including a house or mobile home)?			$
	If yes, please list the location(s), number of acres owned, any expenses (i.e. taxes, insurance, etc.) and any income received:			
19	Do you have any coin collections, antique cars, gems/jewelry, stamps or any other items <u>held for investment purposes</u>?			$
20	Are any assets held jointly with another person?			
	If yes, list person's name and the asset(s) held jointly:			

Please complete the following table for all items checked "YES" on the Household Assets table above:

Question # from above	Family Member	**List name, address and phone number** of Bank or Institution where funds are kept. Provide copy of entire property tax statement for any real estate owned

If you need additional space, please list on the back of this page. Failure to provide the name, address and phone number of the institution(s) where your assets are held will delay the processing of your application.

I/we certify that I/we have _____ have not _____ sold or disposed of any asset for less than Fair Market Value during the two year (24 month) period preceding the date of this application. Any assets sold or disposed of for less than Fair Market Value are identified below.

Recipient's Relationship to Head of Household	Assets Estimated Value	Date Sold / Disposed of	Amount Received

Applicant(s) hereby understand and represent that (1) this application is complete and contains all material facts; and (2) if applicant(s) rent an apartment such rental may be canceled in the event that any statement or information furnished by the applicant is false.

Applicant Signature_____ Date _____

Co- Applicant Signature _____ Date _____

OR

Person authorized to sign on behalf of the Applicant _____

Date _____

Name of any person helping you to complete this application _____
Phone number _____
Relationship to you _____

If we have questions regarding this application should we contact the person assisting you in completing this form? Yes No

Do you have a legal guardian, conservator or power of attorney who can sign on your behalf? Yes No
If yes, please list their name and contact information below. Also, please send proof of guardianship, conservatorship or power of attorney with your application.

Name _____
Address _____
_____
Phone _____

****PLEASE NOTE****

Your application is only valid for 90 days. If you are unable to move into Walden Point within 90 days of submission of this application you will need to complete another application and submit another processing fee.

If your application is approved, when would you like to move into Walden Point?

_____ _____
month year

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

****Applicant/Tenant to complete only the bottom portion of this form.**

TO: (Name and Address of Verifying Entity) DATE: _____

_____

_____

_____ PHONE: _____

_____ FAX: _____

Applicant/Participant Name: _____ Social Security # _____

The individual named directly above is an applicant/tenant of the Federal Housing Tax Credit Program. Federal regulations require that we must verify income in order that the anticipated gross income for the next twelve months may be calculated. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely,_____*Christine Vasquez*_____
Walden Point Administrator

Walden Point
(515) 288-9985 phone
(515) 288-4631 fax

Please return the requested information via fax as soon as possible. If you are unable to fax the information or have any questions please do not hesitate to call us. We appreciate your assistance in helping this applicant secure/maintain affordable housing.

****

TERMS AND CONDITIONS:

Walden Point, its subsidiaries or managing agents may obtain information regarding my income, assets, expenses and household status for purposes of determining my eligibility for participation in the following programs:

- Low Income Housing Tax Credit Program – Section 42
- HUD Housing Assistance Payments Program – Section 8
- Department of Human Services – Elderly Waiver

The information obtained will only be used for determining eligibility in said programs and will be kept confidential and not released outside of this scope.

This release for information will expire thirteen (13) months from the date of signature.

AUTHORIZATION:

I/We hereby authorize release of any information requested by Walden Point regarding my/our income, assets and allowances. I/We understand and agree that photocopies of this authorization may be used for the purpose stated.

_____	_____	_____
Applicant/Tenant Signature	Date	Social Security Number
_____	_____	_____
Co-Applicant/Tenant Signature	Date	Social Security Number

BRIGHTSTAR OF CENTRAL IOWA
1517 NORTH ANKENY BLVD. SUITE E, ANKENY, IA 50023

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

(8/13 revised)

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR 164.508].

Tenant's Name _____ **Birth Date**_____

Address _____

Ph. # _____ **SS #** _____ **MR #**_____

I, the undersigned, do authorize and request:

BrightStar of Central Iowa, 1517 N. Ankeny Blvd. Ste E, Ankeny, IA 50023

_____

(If other than BrightStar of Central Iowa, specify name of person or institution)

_____

(address)

to disclose and/or release protected health information (PHI) including:

_____**Assessment Findings and Health Status Information**_____

(specify dates and type of information to be released)

To _____**Walden Point, 1200 Fourth Street, Des Moines, IA 50314**_____

(name and address of person information is being released to)

The information is to be used for: (Please specify nature, and/or reason for release of information)
Continuing Care_____X_____ Legal _____ Personal _____ Other _____

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to:
(check the appropriate box)

Substance Abuse (alcohol/drug abuse)	[ ]
Mental Health (includes psychological testing)	[ ]
HIV Related Information (Aids related testing)	[ ]

*_____ _____

Signature of Tenant or Legal Guardian Date

* In order for this information to be released, you must sign here and check the appropriate box (es).

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to PHI that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to BrightStar of Central Iowa, 1517 N. Ankeny Blvd. Ste. E, Ankeny, IA 50023.
I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Please type or print name: _____

Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Signature: _____ Date: _____

WALDEN POINT
1200 FOURTH STREET, DES MOINES, IOWA

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

(8/13 revised)

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR 164.508].

Tenant's Name _____ **Birth Date**_____

Address _____

Ph. # _____ **SS #** _____

I, the undersigned, do authorize and request:

Walden Point, 1200 Fourth Street, Des Moines, IA 50314

_____

(If other than Walden Point, specify name of person or institution)

_____

(address)

to disclose and/or release protected health information (PHI) including:

_____**Financial Information**_____

(specify dates and type of information to be released)

To _____**BrightStar of Central Iowa, 1517 N. Ankeny Blvd Ste E, Ankeny, IA 50023**_____

(name and address of person information is being released to)

The information is to be used for: (Please specify nature, and/or reason for release of information)

Continuing Care _____X_____ Legal _____ Personal _____ Other _____

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to PHI that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to Walden Point, 1200 Fourth Street, Des Moines, IA 50314
I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Please type or print name: _____

Signature: _____ Date: _____

Personal Representative: _____Relationship: _____

Signature: _____ Date: _____

HY-VEE
2540 E. Euclid, Des Moines, IA

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

(8/13 reviewed)

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR 164.508].

Tenant's Name _____ **Birth Date**_____

Address _____

Ph. # _____ **SS #** _____ **MR #**_____

I, the undersigned, do authorize and request:

BrightStar of Central Iowa, 1517 N. Ankeny Blvd Ste E, Ankeny, IA 50023

to disclose and/or release protected health information (PHI) including:

_____**Assessment Findings, Health Status Information, and Financial Information**_____
(specify dates and type of information to be released)

To**Hy-Vee, 2540 E. Euclid, Des Moines, Iowa 50317**
(name and address of person information is being released to)

The information is to be used for: (Please specify nature, and/or reason for release of information)
Continuing Care_____X_____ Legal _____ Nutritional_____X_____ Personal _____

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to:
(check the appropriate box)

Substance Abuse (alcohol/drug abuse)	[ ]
Mental Health (includes psychological testing)	[ ]
HIV Related Information (Aids related testing)	[ ]

*_____ _____
Signature of Tenant or Legal Guardian Date

* In order for this information to be released, you must sign here and check the appropriate box (es).

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to PHI that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to BrightStar of Central Iowa, 1517 N. Ankeny Blvd Ste E, Ankeny, IA 50023 and/or Walden Point, 1200 Fourth St., Des Moines, IA 50314.
I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Please type or print name: _____

Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Signature: _____ Date: _____

DOVETAIL SERVICES, LLC
319 E. WASHINGTON, SUITE 111, IOWA CITY, IA

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

(8/13 reviewed)

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR 164.508].

Tenant's Name _____ **Birth Date**_____

Address _____

Ph. # _____ **SS #** _____ **MR #**_____

I, the undersigned, do authorize and request:

BrightStar of Central Iowa, 1517 N. Ankeny Blvd Ste E, Ankeny, IA 50023

to disclose and/or release protected health information (PHI) including:

_____**Assessment Findings, Health Status Information, and Financial Information**_____
(specify dates and type of information to be released)

To**Dovetail Services, LLC, 319 E. Washington, Suite 111, Iowa City, IA 52240**
(name and address of person information is being released to)

The information is to be used for: (Please specify nature, and/or reason for release of information)
Continuing Care_____X_____ Legal _____ Nutritional_____X_____ Personal _____

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to:
(check the appropriate box)

Substance Abuse (alcohol/drug abuse)	[ ]
Mental Health (includes psychological testing)	[ ]
HIV Related Information (Aids related testing)	[ ]

*_____ _____
Signature of Tenant or Legal Guardian Date

* In order for this information to be released, you must sign here and check the appropriate box (es).

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to PHI that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to BrightStar of Central Iowa, 1517 N Ankeny Blvd Ste E, Ankeny, IA 50023 and/or Walden Point, 1200 Fourth St., Des Moines, IA 50314.
I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Please type or print name: _____

Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Signature: _____ Date: _____