SUSAN BAILIS ASSISTED LIVING
352 Massachusetts Avenue
Boston MA 02115
HK| HallKeen Management
HallKeen Assisted Living

RENTAL APPLICATION

*(**Note:** Each co-resident over 18 years of age **must** submit a separate application.)*

APPLICANT

Full Name: _____ Phone #: _____

Social Security #: _____ Initial if over 18 years of age **over 18 years___**

Date of Birth: _____

Occupation: _____Gross Annual Income: _____

Number of Bedrooms Required: ☐ **Studio** ☐ **One Bedroom**

List others to reside in unit:

1. _____

APPLICANT INFORMATION

Present Address:

Street: _____ Apt. #: _____

City: _____ State: _____Zip Code: _____

Rent or Own? _____ Dates: _____ Mthly Payment: _____

Landlord/Lender: _____

City: _____ State: _____ Phone: _____

Previous Address:

Street: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Rent or Own? _____ Dates: _____ Mthly Payment: _____

Landlord/Lender: _____ Street _____

City: _____ State: _____ Phone: _____

Have you ever been evicted from your home for any reason? If so, please give details:

_____

Have you ever been arrested or convicted of any crime? If so, please give details:

_____

Relatives/Emergency Contact (Not residing with you)

1. Name: _____ Relationship: _____

   Address: _____ Phone: _____

2. Name: _____ Relationship: _____

   Address: _____ Phone: _____

How Did You Hear About Us?

☐ Advertisement – If so, which newspaper or website? _____

☐ Friend, family or co-worker – If so, please give us the name of the person who referred you so we can thank them: _____.

☐ Other -- Please explain: _____.

Management shall not make any inquiry concerning race, religious creed, color, national origin, sex, sexual orientation, age (except if a minor), ancestry or marital status of the applicant or concerning the fact that the applicant is a veteran or a member of the armed forces or is handicapped or disabled. The applicant authorizes the Management and/or Renting Agency to obtain or cause to be prepared a consumer credit report relating to the applicant.

Neither the Owner nor the Management is responsible for the loss of personal belongings caused by fire, theft, smoke, water or otherwise, unless caused by their negligence.

The undersigned warrants and represents that all statements herein and on attachments hereto are true and agrees to execute upon presentation a Lease and Residency Agreement, a copy of which the applicant has received or has had occasion to examine, Lease and Residency Agreement may be terminated by the Lessor if any statement herein made is not true. Deposits and/or Assessment Fees are to be applied to actual application processing costs sustained by the owner, except they are to be refunded if said application is not accepted by the owner.

See Attachment to Rental Application for Employment / Income Information.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Applicant Date

Resident Contact Form **Today's Date:** _____

Resident's Name: _____ Unit: _____

DOB: _____ Age: _____ SS#: _____

Lease Date: _____ Move in Date: _____

Sex: F/ M Religion: _____

Marital Status: Single:____ Married:____ Divorced:____ Widowed:____

Name of Spouse: _____

If your spouse is deceased, what is the date of death? _____

Birthplace: _____ (State/ Country) _____

Citizenship (USA/ Other): _____

Representatives and Emergency Contact Preferences
If there is someone designated to manage your affairs, please describe type of power given (i.e., financial, durable, medical, conservator, guardian) and list name, address, and phone number of person who holds such power. Please furnish a complete copy of the authorizing document, as well as any trust documents, which may pertain to these Powers.

Representative 1/ *Billing Representative:*
Name: _____Relationship: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: (_____) _____-_____
Cell: (_____) _____-_____
E-mail: _____

Type of Power Given:
- Responsible Party
- Power of Attorney (Type(s): _____)
- Healthcare Proxy
- Emergency Contact – Primary / Secondary / Tertiary (Circle One)
- Other (Guardian, Conservator, etc.) _____

Representative 2:
Name: _____Relationship: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: (_____) _____-_____
Cell: (_____) _____-_____
E-mail: _____

Type of Power Given:

- Responsible Party
- Power of Attorney (Type(s): _____)
- Healthcare Proxy
- Emergency Contact – Primary / Secondary / Tertiary (Circle One)
- Other (Guardian, Conservator, etc.) _____

Insurance Information:

Please list all of your medical insurance coverage, including supplemental and long-term care:

_____Policy # _____
_____Policy # _____
_____Policy # _____

Health Information:

Primary Care Physician's Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: (_____) _____-_____
Fax: (_____) _____-_____
Physician's Specialty:
_____

Pharmacy: _____
Phone: (_____) _____-_____

Dentist: _____
Phone: (_____) _____-_____

Other Health Care Providers seen by resident, if any:

1) Physician's Name: _____
Phone: (_____) _____-_____
Physician's Specialty: _____

2) Physician's Name: _____
Phone: (_____) _____-_____
Physician's Specialty: _____

- Do you have a DNR/ MOLST? Yes/ No
- Allergies: _____
- Special Diet:_____