THIS BOX IS FOR OFFICE USE ONLY

Date of receipt: _____

Time of Receipt: _____

Control Number: _____

Bedrooms: _____

BILLERICA HOUSING AUTHORITY
16 River Street
Billerica, MA 01821
978-667-2175

TRANSFER APPLICATION FOR STATE-AIDED PUBLIC HOUSING

Incomplete applications will not be processed. Please complete all information reqested on the application. If a question is not applicable, please write N/A. Make sure you sign the last page.

(PLEASE PRINT)

This is an application to move from one Housing Authority managed apartment to another. The Housing Authority may require you to provide third party verification of the reason for this request.

1. Name of Applicant: _____

   Current Address: _____ Apt. No. _____

   Home Telephone:(____)_____ Work Telephone: (____)_____

2. Reason for Request: (circle one)

   Apartment too small for household — Medical reasons

   Apartment too big for household — Other (specify)_____

3. Written description of reason for request to transfer: _____

4. Current Apartment size:_____bedrooms

5. Current Household Composition:

First name, middle initial, and last name of everyone living in the household	Sex	Age

APPLICANT'S CERTIFICATION

I certify that the information I have given in this application is true and correct, and I understand that any false statement or misrepresentation may result in the cancellation of my application. I understand that the Housing Authority will make no more than one offer of an appropriate unit and if I do not accept that offer within 7 days of the date of the written offer, my application will be removed from the transfer list. I authorize the Housing Authority to make inquiries to verify the information that I have provided in this application.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

Applicant's Signature Date

Reviewer's Signature Date

BILLERICA

HOUSING AUTHORITY

16 River Street
Billerica, MA 01821
Tel 978-667-2175
978-667-1661
Fax 978-667-1156

Name of Physician_____

Physician's Address_____

_____

Date_____

PHYSICIAN'S VERIFICATION OF MEDICAL IMPAIRMENT FOR TRANSFER WITHIN PUBLIC ELDERLY/HANDICAPPED HOUSING

_____ _____
Applicant's Name Applicant's Control Number

_____

_____
Applicant's Address

I hereby authorize release of the following information:

_____
Applicant's Signature

The Housing Authority's policy is to obtain a physician's certification documenting that a tenant has a qualifying physical or mental impairment in order to determine the applicant's eligibility for a medical transfer. The applicant has authorized above your release of the requested information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact our office at 978-667-1661. Thank you for your anticipated cooperation.

Sincerely,

Robert Correnti, Executive Director

7/03

TO BE COMPLETED BY PHYSICIAN

1. Does the applicant have a compelling and documented medical impairment which could be substantially improved by a transfer to another available unit? YES NO

2. Is the transfer requested from a second to first floor unit? YES NO

3. Please describe the medical condition and compelling need._____
_____
_____
_____
_____
_____

4. What is the anticipated duration of the Applicant's impairment? (If indefinite so specify, and estimate the approximate duration to the best of your ability)._____
_____
_____
_____

PHYSICIAN'S CERTIFICATE

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____ Date:_____
Signature MD

Name:_____ Address:_____

Telephone No.(___)_____