Smithfield Gardens Assisted Living

2024 Information & Application Package

26 Smith Street, Seymour, CT 06483 (203) 888-1835

The State of Connecticut Assisted Living Demonstration Program

We offer seniors a combination of housing and services that include meals, housekeeping, laundry, recreational activities and personal care, while promoting dignity and independence!

Professionally managed by

The Housing Authority of the Town of Seymour
28 Smith Street, Seymour, CT 06483

Financed by CHFA

EQUAL HOUSING OPPORTUNITY

www.smithfieldgardens.org

Community Amenities

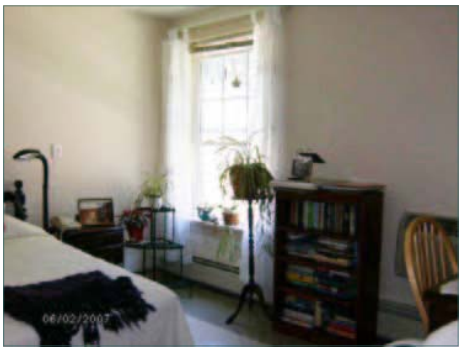
- Full Service Dining Room
- Fireplace Lounge
- Library
- Beauty Parlor
- Country Kitchen
- Multi-Purpose Room
- TV Lounge
- Private Dining Room
- Laundry Facilities
- Mail Room
- Resident Storage
- Secured Building
- Patio
- Courtyard
- On-site Management
- In-House Emergency Response Pendant System

Resident Services

- Weekly laundry and housekeeping
- Daily social and recreational activities
- Transportation scheduling for local medical appointments, local shopping, and activities
- 24-hour staffing
- Personal assistance with activities such as bathing, dressing, and medication management

Apartment Amenities

- Kitchen area with full-size refrigerator, microwave, and two-burner cook top
- Living room area
- Bedroom with ample closet space
- Bathroom with grab bars, walk-in shower, and bench seat
- Emergency call-for-aid system
- Heat, hot water, electricity, and basic cable included in rent



Smithfield Gardens Assisted Living is a managed residential community and is overseen by the Connecticut Department of Public Health. Our community offers assisted living services through a contractual arrangement with Utopia Assisted Living Service, Inc., a Connecticut licensed assisted living services agency.

Smithfield Gardens Assisted Living

General Information for 2024

To qualify for residency at Smithfield Gardens, individuals must:

1. Be at least 65 years of age

2. Have a documented gross annual income between $18,348 and $54,840 for a single person or between $26,256 and $62,640 for a couple*

3. Meet the requirements of the CT Home Care Program for Elders (CHCPE) sponsored by the Department of Social Services (DSS) which include an asset limit of $46,242 for a single person and $61,656 for a couple.**

*Income limits are established each year by the Department of Housing and Urban Development and are subject to change. Amounts shown are current as of April 1, 2024.

**Asset limits are determined by the Department of Economic and Community Development in conjunction with DSS and are subject to change. Limits shown are current for 2024.

Current rental rates for an apartment are $870 or $1,030 depending upon the amount of an individual's gross annual income. (Rental rates are subject to change each year. Rates shown are current for 2024.)

The Meal Plan consists of three meals per day prepared by a professional chef and served in our Dining Room. The current monthly cost for the Meal Plan is $495. This amount is periodically reviewed and is subject to change.

As a reminder, Smithfield Gardens Assisted Living became a smoke-free community as of January 1, 2012.

All new residents are required to be fully vaccinated for COVID-19 prior to moving into the community.

Smithfield Gardens Assisted Living

26 Smith Street, Seymour, CT 06483
Phone: (203) 888-1835 **Fax**: (203) 888-1836 **Email**: info@smithfieldgardens.org

Thank you for your interest in our community!

Please review all the enclosed literature and feel free to call us with any questions.

To apply for our community, **please complete and return the following documents**:

1. **Application for Housing**: Please complete the form in ink in its entirety. Do not leave any blanks. If a question does not apply to you, please write "N/A". *The use of white-out is not permitted*. In addition, if you cross-out any information, please initial the cross-out. Please remember to sign and date the application. If someone else fills out the application on your behalf, please be sure to complete Section H of the form.
2. **Resident Statement**: Please complete and sign.
3. **Sponsor Statement**: Please have a family member or friend complete and sign this form.
4. **Waiting List Policy**: Please complete and sign.
5. **Notice and Consent for the Release of Information**: Please complete and sign.
6. **CT Home Care Program Request for Referral**: Please complete and sign.
7. **Copies of:** **Your COVID-19 Vaccination Card**
   Your Social Security Card
   Your Birth Certificate
   Your Social Security Award Letter (if you don't have a copy, you can request one from the Social Security Administration at 1-800-772-1213)

Please return the completed application packet to:

Smithfield Gardens Assisted Living
26 Smith Street, Seymour, CT 06483

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PLEASE VISIT OUR WEBSITE FOR CURRENT RATES AND UPDATED INCOME/ASSET REQUIREMENTS

www.smithfieldgardens.org

Smithfield Gardens Assisted Living

APPLICATION FOR HOUSING

Low-Income Housing Tax Credit Property / Assisted Living

Please Print Clearly. DO NOT LEAVE ANY BLANKS. DO NOT USE WHITE-OUT.
If an item does not apply to you, write "N/A".

This is an application for housing at:	*Smithfield Gardens Assisted Living* 26 Smith Street Seymour, CT 06483
Please complete this application, **attach all required documents,** and return to:	*Smithfield Gardens Assisted Living* 26 Smith Street Seymour, CT 06483

Applications are placed in order of date and time received.
An applicant may be interviewed only after the receipt of this tenant application.

A. GENERAL INFORMATION

Applicant Name(s): _____

Address: _____
Street Apt. # City State ZIP

Cell Phone: _____ Home Phone: _____

Email Address: _____

No. of BR's in current unit: _____ Do you ☐ RENT or ☐ OWN (check one)

Amount of current monthly rental or mortgage payment: $ _____

If owned, do you receive monthly rental income from property? ☐ Yes ☐ No (check one)

Check utilities paid by you**:** ☐ Heat ☐ Electricity ☐ Gas ☐ Other (specify)_____

Approximate monthly cost of utilities paid by you (excluding phone and cable TV): $ _____

Bedroom size requested: ☐ One BR ☐ Accessible

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B. HOUSEHOLD COMPOSITION

List all persons who will live in the apartment. List the head of household first.

	Name	Relationship to Head	Birth Date	Age (optional)	Social Security Number (last 4 digits)	Student Y/N
Head						
Co-Head						

Will all listed minors be living in the unit at least 50% of the time? ☐ Yes ☐ No

If not, explain custody arrangement (proof of custody may be required): _____

1. Have there been any changes in household composition in the last twelve months?	☐ Yes	☐ No
If yes, explain:		
2. Do you anticipate any changes in household composition in the next twelve months?	☐ Yes	☐ No
If yes, explain:		
3. Is there someone not listed above who would normally be living with the household?	☐ Yes	☐ No
If yes, explain:		
4. Are you living with anyone now who will not be moving into this unit with you?	☐ Yes	☐ No
If yes, explain:		

5. Will all of the persons in the household be or have been full-time students during five calendar months of this year or plan to be in the next calendar year at an educational institution (other than a correspondence school) with regular faculty and students?	☐ Yes	☐ No
IF YES, ANSWER THE FOLLOWING QUESTIONS (6-10):		
6. Are any full-time student(s) married and filing a joint tax return?	☐ Yes	☐ No
7. Are any student(s) enrolled in a job-training program receiving assistance under the Job Training Partnership Act?	☐ Yes	☐ No
8. Are any full-time student(s) a TANF or a title IV recipient?	☐ Yes	☐ No
9. Are any full-time student(s) a single parent living with his/her minor child who is not a dependent on another's tax return and whose children are not dependents of anyone other than a parent?	☐ Yes	☐ No
10. Is any student a person who was previously under the care and placement of a foster care program (under Part B or E of Title IV of the Social Security Act)?	☐ Yes	☐ No

C. INCOME

List ALL sources of income as requested below. If a section doesn't apply, cross out or write NA.

Household Member Name	Source of Income	Gross Monthly Amount
11.	Social Security	$
12.	Social Security	$
13.	SSI Benefits	$
14.	SSI Benefits	$

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C. INCOME

List ALL sources of income as requested below. If a section doesn't apply, cross out or write NA.

Household Member Name	Source of Income	Gross Monthly Amount
15.	Pension (**list source**):	$
16.	Pension **(list source**):	$
17.	Veteran's Benefits (**list claim #**):	$
18.	Veteran's Benefits (**list claim #**):	$
19.	Unemployment Compensation	$
20.	Public Assistance (Title IV/TANF etc.)	$
21.	Contributions to the Household (monetary or not)	$
22.	Full-Time Student Income (18 & Over Only)	$
23.	Financial Aid (excluding loans)	$
24.	Annuities (list sources)	$
25.	Annuities (list sources)	$
26.	Long Term Medical Care Insurance Payments in excess of $180/day	$
27.	Scheduled Payments from Investments	$
28.	Retirement Account Payments (including RMDs)	$
29.	Income from Rental Prroperty	

Household Member Name	Source of Income	Monthly Amount
30.	Employment Amount:	$
	Employer Name:	
	Employer Address:	
	Position Held:	
	Length of Employment:	
31.	Employment Amount:	$
	Employer Name:	
	Employer Address:	
	Position Held:	
	Length of Employment:	
32.	Employment Amount:	$
	Employer Name:	
	Employer Address:	
	Position Held:	
	Length of Employment:	
33.	**Previous Employment Amount (last 60 days):**	$
	Employer Name:	
	Employer Address:	
	Position Held:	
	Length of Employment:	

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Household Member Name	Source of Income	Monthly Amount
34.	**Alimony**	
	Are you ***legally entitled*** to receive alimony?	☐ Yes ☐ No
	If yes, list the amount you are ***entitled*** to receive.	$
	Do you receive alimony?	☐ Yes ☐ No
	If yes list amount you receive.	$
35.	**Child Support**	
	Are you ***legally entitled*** to receive child support?	☐ Yes ☐ No
	If yes list the amount you are ***entitled*** to receive.	$
	Do you receive formal/informal (money, items, etc.) child support? ***If a court order exists, it will need to be provided with a current payment history from the enforcement agency.***	☐ Yes ☐ No
	If yes, list the amount you receive.	$
36.	**Other Income** (describe:)	$
37.	**Other Income** (describe:)	$
38.	**Other Income** (describe:)	$
39. ***TOTAL GROSS ANNUAL INCOME*** (Based on the monthly amounts listed above x 12)		$
40. TOTAL GROSS ANNUAL INCOME FROM PREVIOUS YEAR (Do **NOT** leave this blank)		$

41. Do you anticipate any changes in this income in the next 12 months?	☐ Yes	☐ No
42. Is any member of the household legally entitled to receive income assistance?	☐ Yes	☐ No
43. Is any member of the household likely to receive income or assistance ***(monetary or not)*** from someone who is not a member of the household as listed on Page 2 etc)?	☐ Yes	☐ No
44. **If yes to any of the above**, explain:		
45. Is the income received?	☐ Yes	☐ No

D. ASSETS

If your assets are too numerous to list here, please request an additional form.
If a section doesn't apply, cross out or write NA.

46. Checking Accounts	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
47. Savings Accounts	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
48. Trust Accounts	#:	Bank:	Balance: $
49. Debit Cards **NOT** associated with a checking account	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
50. Certificates of Deposit	#:	Bank:	Balance: $
	#:	Bank:	Balance: $

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D. ASSETS

If your assets are too numerous to list here, please request an additional form.
If a section doesn't apply, cross out or write NA.

51. Money Market Accounts	#:	Bank:	Balance: $
	#:	Bank:	Balance: $
52. Savings Bonds	#:	Maturity Date:	Value: $
	#:	Maturity Date:	Value: $
	#:	Maturity Date:	Value: $
53. Life Insurance Policy	#:	Source:	Cash Value: $
54. Life Insurance Policy	#:	Source:	Cash Value: $

55. Mutual Funds	Name:	# Shares:	Interest or Dividend: $	Value: $
	Name:	# Shares:	Interest or Dividend: $	Value: $
	Name:	# Shares:	Interest or Dividend: $	Value: $
56. Stocks	Name:	# Shares:	Dividend Paid: $	Value: $
	Name:	# Shares:	Dividend Paid: $	Value: $
	Name:	# Shares:	Dividend Paid: $	Value: $
57. Bonds	Name:	# Shares:	Interest or Dividend: $	Value: $
	Name:	# Shares:	Interest or Dividend: $	Value: $

58. Real Estate Property: ***Do you own any property?***	☐ Yes ☐ No
If yes, Type of property:	
59. Location of property:	
60. Appraised Market Value:	$
61. Mortgage or outstanding loans balance due:	$
62. Amount of annual insurance premium:	$
63. Amount of most recent tax bill:	$
64. Is the property subject to foreclosure, bankruptcy, or eviction?	☐ Yes ☐ No
If yes, describe:	
65. Have you sold/disposed of any property in the last 2 years?	☐ Yes ☐ No
If yes, type of property:	
66. Market value when sold/disposed:	$
67. Amount sold/disposed for:	$
68. Date of transaction:	
69. Have you disposed of any other assets in the last 2 years (Example: Given away money to relatives, set up Irrevocable Trust Accounts)?	☐ Yes ☐ No
If yes, describe the asset:	
70. Date of disposition:	
71. Amount disposed:	$

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72. Do you have any other assets not listed above (excluding personal property)?		☐ Yes ☐ No
If yes, please list:		

E. ADDITIONAL INFORMATION		
73. Are you or any member of your family currently using an illegal substance?	☐ Yes	☐ No
74. Have you or any member of your family ever been convicted of a felony?	☐ Yes	☐ No
If yes, describe:		
75. Have you or any member of your family ever been evicted from any housing?	☐ Yes	☐ No
If yes, describe:		
76. Have you ever filed for bankruptcy?	☐ Yes	☐ No
If yes, describe:		
77. Will you take an apartment when one is available?	☐ Yes	☐ No
Briefly describe your reasons for applying:		

F. REFERENCE INFORMATION

78. Current Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	
79. Prior Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	

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80. Credit Reference #1:	
Address:	
Account #:	Phone #:
81. Credit Reference #2:	
Address:	
Account #:	Phone #:
82. Personal Reference #1:	
Address:	
Relationship:	Phone #:
83. Personal Reference #2:	
Address:	
Relationship:	Phone #:
84. Personal Reference #3:	
Address:	
Relationship:	Phone #:
85**. In case of emergency notify:**	
Address:	
Relationship:	Phone #:

G. VEHICLE AND PET INFORMATION (if applicable)

List any cars, trucks, or other vehicles owned. Parking will be provided for one vehicle. Arrangements with Management will be necessary for more than one vehicle.

86. Type of Vehicle:	License Plate #:		
Year/Make:	Color:		
87. Type of Vehicle:	License Plate #:		
Year/Make:	Color:		
88. Do you own any pets?		☐ Yes	☐ No
If yes, describe:			

H. APPLICATION ASSISTANCE

89. Did anyone help/assist you in filling out this application? ☐ Yes ☐ No

If yes, state who assisted you and the reason for the assistance:_____

_____

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I. Other Information

Critical needs are defined as "Activities of Daily Living" which are hands-on activities that are essential needs for an individual's health and safety. Please check any of the following activities that you may require assistance with:

☐ Bathing ☐ Eating ☐ Meal Preparation ☐ Medication Management

☐ Dressing ☐ Transfers ☐ Toileting

For statistical purposes only (please check all that apply):

_____ American Indian/Alaska Native
_____ Asian
_____ Black/African American
_____ Native Hawaiian/Other Pacific Islander
_____White
_____ Other
_____ Hispanic
_____ Non-Hispanic

STATEMENT OF POLICY

We provide an EQUAL HOUSING OPPORTUNITY for all applicants. No decision is based on any criteria that would violate any state or federal regulation on discrimination. We adhere to the policies and guidelines set forth in our Tenant Selection Plan. A copy of the Tenant Selection Plan is available for applicants' review at the main office and any on-site rental offices. Credit/criminal/ eviction background checks are made on all applicants age 18 and over. Rejection letters, as provided by law, are mailed to all applicants who are rejected.

APPLICANT(S)' CERTIFICATIONS:

I/we certify that I/we do not and will not maintain a separate subsidized rental unit in another location. I/we further certify that this will be my/our only permanent residence. I/We understand I/We must pay a security deposit for this apartment prior to occupancy. I/We understand that my eligibility for housing will be based on applicable income limits and by management's selection criteria. I/we certify that all information in this application is true to the best of my/our knowledge and I/We understand that false statements or information are punishable by law and will lead to cancellation of this application or termination of tenancy after occupancy. All adult applicants, 18 or older, must sign application.

I/we authorize the owner/manager/agent to verify all information contained herein, and I/we consent to the release of necessary information to determine my/our eligibility.

I/we understand that a consumer background report (retail credit history, rental history, and/or arrest and/or conviction records) will be processed by the owner/manager.

I/we hereby authorize law enforcement agencies to release criminal records and/or sex offender registration information to the owner/manager/agent or to an agency contracted by the owner/manager/agent to conduct criminal background checks.

I/we consent to be contacted by telephone at the telephone number(s) I/we have listed herein with regard to the availability and acquisition of housing at the community to which I/we have applied.

I/we hereby release all owners, managers, and employees, or agents, both of landlord and their credit checking agencies from any action whatsoever, in law and equity, in connection of processing, investigating, or credit checking this application, and will hold them harmless from any suit or reprisal whatsoever.

SIGNATURE(S) **(Must be dated)**:

_____ _____
Signature of Head of Household Date

_____ _____
Signature of Co-Head Date

_____ _____
Signature of Other Household Member Age 18 and Over Date

Title 18, Section 1001 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the United States as to any matter within its jurisdiction.

Smithfield Gardens Assisted Living

26 Smith Street
Seymour CT, 06483
Phone: (203) 888-1835 **Fax**: (203) 888-1836

Resident Statement

I, _____, the applicant, understand and am aware that the Smithfield Gardens Assisted Living is designed for elderly individuals who are capable of living independently and who may benefit from assisted living services to maintain independent living, *but who do not need the skilled care of a nursing home*.

Further, I understand and agree that in the event that I am not capable of living independently and that I require more services and assistance than are available at the Smithfield Gardens Assisted Living, due to increased disability, physically or mentally as determined by Seymour Housing Authority, the Managing Agent, I will make necessary arrangements to relocate to a facility that will better suit my medical and personal needs.

Furthermore, I will notify The Seymour Housing Authority, in the event I decide to relocate, 30 days prior to my vacancy, so my records and the Seymour Housing Authority's records can be properly updated.

_____ _____

Date Signature

_____ _____

Date Signature

Smithfield Gardens Assisted Living

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Seymour CT, 06483
Phone: (203) 888-1835 **Fax**: (203) 888-1836

Sponsor Statement

I, _____, the undersigned, agree to be responsible for the care and needs of _____(Applicant). I agree to be the contact person in case of an emergency or other problem arising from the sponsored individual, and I agree to assist the Director of Smithfield Gardens Assisted Living, the Supervisor of Assisted Living Services, and/or other staff members if so requested with the resolution of any such emergency or problem. As a sponsor, I understand that I may be asked to assist the sponsored individual with the purchase of routine items not supplied by Smithfield Gardens in the event that the sponsored individual is unable to make such purchases himself/herself (i.e. toilet paper, paper towels, toothpaste). I understand that I may also be required to assist the applicant with scheduling medical appointments and transportation and with completing any annual documentation required for continued occupancy.

Further, I understand that if the sponsored individual becomes incapable of independent living due to increased physical or mental disability, as determined by Smithfield Gardens Assisted Living or by the Supervisor of Assisted Living Services, I will be totally responsible for relocating the sponsored individual to a facility better suited for his/her needs.

In addition, I understand that I am not responsible for any financial obligations.

I agree to notify Smithfield Gardens Assisted Living if there should be any change in my ability to sponsor this individual.

_____ _____
Signature Date

Address: _____
_____

Email: _____
Telephone: Home: _____
Work: _____
Cell: _____

Smithfield Gardens Assisted Living

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Waiting List Policy

I/We, the applicant(s), understand that once my/our application is reviewed and processed to be eligible for housing in Smithfield Gardens Assisted Living Facility under Section 42 of the Internal Revenue Code (the Low Income Housing Tax Credit Program) and under the requirements of the Connecticut Home Care Program through the Department of Social Services, my/our name will be placed on the waiting list based by the date and time my/our application was received.

Further, I/we understand that I/we am required to notify the Seymour Housing Authority if anything changes that would affect my/our application or contact information.

Furthermore, I/we understand that once a year a mailing may be conducted to purge the waiting list of applicants that are no longer interested in living at Smithfield Gardens Assisted Living. If, during the course of purging the list, mailed items are sent to me/us and returned by the postal service to the Seymour Housing Authority, my/our name will be removed from the waiting list. If my/our name is removed from the waiting list, I/we may reapply and my/our name will be placed at the bottom of the list and treated as a new applicant.

_____ _____

Date Applicant Signature

_____ _____

Date Applicant Signature

Smithfield Gardens Assisted Living

26 Smith Street
Seymour CT, 06483
Phone: (203) 888-1835 **Fax**: (203) 888-1836

Notice and Consent for the Release of Information

I/We understand that by signing this consent form, I/we authorize the Seymour Housing Authority to request information from third parties about me/us. I/We understand that I/we have applied for housing assistance in a development operating under the "Low-Income Housing Tax Credit" Program of Section 42 of the Internal Revenue Code. Provisions of this code require the housing owner to verify all information that is used in determining my/our eligibility and level of benefits to ensure that I/we am/are eligible for assisted housing benefits and that these benefits are set at the correct level.

The information obtained by signing this consent form includes verification of information.

In addition, by signing this consent form, I/we authorize the release of information concerning my/our income, assets, landlord references, credit, criminal background checks, and medical history (which may include disability, frequency and duration of treatment, information to establish evidence of rehabilitation, or my/our ability to live independently in and to maintain my dwelling unit).

I/We hereby consent to and authorize the release of requested information.

_____ _____

Date Applicant Signature

_____ _____

Date Applicant Signature

CONNECTICUT HOMECARE PROGRAM FOR ELDERS (CHCPE) REQUEST FOR REFERRAL

Section A **APPLICANT'S PERSONAL INFORMATION**

Applicant's Last Name_____ First Name_____

Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security Number_____ Gender: ☐ Male ☐ Female

Address (of applicant)_____

Phone _____ Medicaid Number (if you have one) _____

I live: (check one) ☐ Alone ☐ With family ☐ Group home ☐ Assisted living

Section B **Financial Assessment**

1. My monthly income is: $_____ **2**. My (total) assets are: $_____

Notice to Married Couples – Under state and federal law, a married couple can protect assets for the spouse who is living at home while the other spouse is either in a nursing home or receiving nursing home level-of-care at home. This process is called a Spousal Assessment. You can request a Spousal Assessment before you apply for state or federal services.

☐ Yes ☐ No I would like a **Spousal Assessment** to see what I can protect for my spouse.

SECTION C **Functional Assessment**

1. Personal Needs: Tell us if you need help with these tasks. (Write the number of help you need):

0 = No help 1 = Supervision / Reminders Needed 2 = Hands-on help 3 = Total dependence

Bathing _____ Dressing_____ Eating _____ Toileting_____ Transfer (in and out of bed/chairs) _____

Walking _____ Medications _____ (Do you need help taking your daily meds? If so, tell us how much help you need.)

Continence (Bowel and/or Bladder Control) _____ Meal Preparation_____

2. Living Arrangements: (Circle one)

Homeless Home with Family Home Alone Group Home Shelter Other _____

At home, does someone from your family or community (neighbors) help you whenever you need it? Yes No

3. Behavioral Problems: (Circle all that apply)

Wandering Abusive / Assaultive Self Injurious Verbally Aggressive Unsafe / Unhealthy Habits Threats to safety

4. Medical Diagnosis or Condition: (Write in below)

_____

Section D **Point of Contact**

Please contact me instead of the applicant: Name_____

(I am the Point of Contact for the applicant)

Phone_____ Relationship (family, friend, etc.)_____

I am the:
- Power-of-Attorney
- Conservator
- Guardian

(Circle if appropriate)

X_____

Applicant's signature or mark (X) **Date** **Witness' signature if signed with an X**

_____

Person completing form on applicant's behalf **Relationship** **Phone Number**

FACILITY STAFF ONLY: Please complete if the person is in a hospital or a nursing home. (Not needed if a health screen is attached.)

Name of facility:_____

Staff Member / Date _____ **Phone #**_____

REMEMBER! A fully completed form will prevent delays in processing your application.