CONNECTICUT HOUSING FINANCE AUTHORITY

Dear Friend:

We are enclosing the application which you requested for the Reverse Annuity Mortgage (RAM) loan in connection with Long Term Care (LTC) offered by the Connecticut Housing Finance Authority (CHFA). We are also enclosing a brochure which should answer most questions about the program.

The application asks you to provide us with certain information. Most of this information is necessary for us to tell whether or not you are likely to be eligible for the CHFA program.

Filling out the application does not mean that you are required to take the loan. This is just a preliminary application. You will be discussing the program and final application with a CHFA representative.

Please return the application to:

Mr. Horace McCaulley
Elderly Services Division
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Thank you for your interest.

Sincerely,

Linda M. Iglesias

Linda M. Iglesias
Mortgage Specialist

LMI/
Enclosures

HMORT\RAM\RAMS

999 West Street / Rocky Hill, Connecticut 06067-4005 / 203-721-9501

CONNECTICUT HOUSING FINANCE AUTHORITY

PRELIMINARY APPLICATION FORM
Reverse Annuity Mortgage (RAM)

PLEASE TYPE OR PRINT LEGIBLY

1. Names and dates of birth of all titleholders to the property. Please include any spouses of titleholders now living with them, whether or not the spouse is a titleholder.

Applicant's Name _____ (Last), _____ (First) _____ (Middle Initial)

Date of Birth _____

Spouse's Name _____ (Last), _____ (First) _____ (Middle Initial)

Date of Birth _____

Other Titleholder(s):

Name _____ (Last), _____ (First) _____ (Middle Initial)

Date of Birth _____

2. Address of Principal Residence:

_____
Number Street Apt. No.

_____

_____
City/Town Zip Code

Telephone Number: (_____) _____-_____

3. Contact Person (if applicable):

_____ (Last), _____ (First) _____ (Middle Initial)

_____
Number Street Apt. No.

_____

_____
City/Town Zip Code

Relationship to Applicant(s) _____

Telephone Number: (_____) _____-_____

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4. **Total Household Income for Previous Calendar Year:**

A. Total Income of a Taxable Nature, for previous calendar year $_____

B. Non-taxable Income:

1) Social Security $_____

2) Municipal Bond Interest $_____

3) Other $_____

4) Total Non-taxable Income [Add 1), 2), and 3)] $_____

D. Total Income [add A. and B. 4)] $_____

5. **How long have you lived at the residence?** _____ Years

6. **Is there any lien or encumbrance on the property?** _____ Yes _____ No

If yes, please indicate type and amount:

Mortgage $_____

Back Taxes $_____

Mechanics Lien $_____

Other $_____

7. **Do you think that you will want a lump-sum payment of up to $5,000 to be used for any purpose?**

_____ Yes _____ No

8. If your answer to number 7. was "yes", what is your reason for wanting the lump sum? *(You are not required to answer this question if you do not wish to.)*

_____ Clear existing liens _____ Medical bills

_____ Home repairs _____ Other

9. What is your estimate of the current fair market value of this property?

$_____

10A. If you are married, do you and your spouse own the property jointly, with rights of survivorship?

_____ Yes _____ No

10B. If the answer to 10A. above is "No", would you be able and willing to place the property in joint ownership with rights of survivorship before signing the papers for the CHFA Reverse Annuity Mortgage?

_____ Yes _____ No

11. Is your home a condominium? _____ Yes _____ No

LONG TERM CARE (LTC)

12. Do you currently have a CHFA Reverse Annuity Mortgage Loan?

☐ Yes ☐ No

13. Name of household member(s) requiring long term care assistance:

_____

_____

14. Is any household member living outside of the home? ☐ Yes ☐ No

If so, where? _____

15. Describe the nature of the chronic illness or condition; and, if not institutionalized, list the activities for which assistance is needed:

_____

_____

_____

_____

_____

_____

_____

16. Physicians under whom household member(s) is currently receiving treatment:

Name of Physician	Address
_____	_____
_____	_____
_____	_____
_____	_____

17. If lump sum payment larger than $5,000 (up to $25,000) for medical purposes is requested, please indicate how much.

$_____ Total Lump Sum

18. **Indicate nature and estimated cost of long term care, if any, for which a larger lump sum payment (exceeding $5,000) is requested:**

	Estimated Cost
A. _____	$_____
B. _____	$_____
C. _____	$_____
TOTAL ESTIMATED COST	$_____

19. **Estimate of current monthly long term care costs:**

Type of Service or Equipment	Provider and Phone Number	Est. Monthly Cost Paid By Applicant
A. _____	_____	$_____
B. _____	_____	$_____
C. _____	_____	$_____
D. _____	_____	$_____
	TOTAL ESTIMATED MONTHLY COST PAID BY APPLICANT	$_____

Authorization Statement

I (or my designee) hereby authorize the State of Connecticut Division of Elderly Services, the Connecticut Housing Finance Authority, and their designees to verify any information on this application. For this purpose, contact may be made with physicians, service providers, or others, as required. I understand this information will be kept confidential.

Signature of Applicant (or designee)	Typed or Printed Name	Date
Signature of Co-Applicant (or designee)	Typed or Printed Name	Date