Review Form for the Projects in the Age-Friendly Senior Cycle

This property, in receiving a Low Income Housing Tax Credit allocation was selected in part due to the Owner's commitment to provide services to residents at the property. As part of NJHMFA annual monitoring, the owner must complete and submit the following information. Review NJ HMFA's Compliance Monitoring Manual for further detail on the requirements of this annual monitoring form. Failure to comply with the social service requirements committed to in the application is grounds for a determination of noncompliance.

Please submit this completed form and relevant items in the checklist below must be used when submitting social service or special needs packages to HMFA for approval. *Please fill out this form and check off each item as it pertains to the property and submit the complete package on or before January 31st.*

REVIEW FORM FOR PROJECTS IN THE AGE-FRIENDLY SENIOR CYCLE

LIHTC #:	HMFA # (if applicable):
Property Name:	Property Address:
Credit Allocation Year:	Compliance Year: 2024

Identify the services being provided to the residents of this building by completing the relevant row categories for each service provided.

Transportation				
Name of provider	Frequency (days/hours available)	What places transportation is provided to	Cost of the service and who pays for service (tenant-paid, free of charge, etc.)	*What documentation is included as an attachment?*
Participation in the SIL program				
Name of SIL Coordinator	Numbers of hours per week onsite	Number of residents utilizing services in a month (on average)		*SIL Coordinator job description is included as documentation, in addition to this completed form*

On-site health provider with a private room			
Name of health care provider	Number of hours service provider is on site per month	Number of residents utilizing services in a month (on average)	*What documentation is included as an attachment?*

Other Services Provided (i.e., On-site Pharmacy, Wellness Clinic, Satellite Hospital Office, PACE program, Assisted Living Program (ALP), Medical Day Care Program Licensed Assisted Living Facility or Other Similar Programs)				
Indicate which service is being provided	Name of service provider	Number of hours service provider is onsite per week	Number of residents served in a month (on average)	*What documentation is included as an attachment?*

Accessible outdoor spaces
What outdoor spaces are being used and how by tenants

Exercise Room
Indicate how this room is being used on a monthly basis

OWNER CERTIFICATION

By signing this form, the Owner is confirming the social services committed to at the time of the LIHTC application are being provided to residents of this property.

Owner's Signature: _____ Date: _____

Owner's Name: _____
Owner's Title: _____

Review Form for the Projects in the Age-Friendly Senior Cycle

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REVIEW FORM FOR PROJECTS IN THE AGE-FRIENDLY SENIOR CYCLE

LIHTC #: 12345	HMFA # (if applicable): 1234
Property Name: Great View Drive	Property Address: 1234 Great View Drive Anytown, New Jersey XXXX
Credit Allocation Year: 1998	Compliance Year: 2024

Identify the services being provided to the residents of this building by completing the relevant row categories for each service provided.

Transportation				
Name of provider	Frequency (days/hours available)	What places transportation is provided to	Cost of the service and who pays for service (tenant-paid, free of charge, etc.)	*What documentation is included as an attachment?*
Anytown Transit	2x week, pick up at front of building	Grocery Store Doctor's Office Prescheduled Outings	Suggested $1 per trip	Recent (in the last years) Letter on Anytown Transit

				Letter head, providing a short description of relationship with Great View Drive
Participation in the SIL program				
Name of SIL Coordinator	Numbers of hours per week onsite	Number of residents utilizing services in a month (on average)		*SIL Coordinator job description is included as documentation, in addition to this completed form*
Suzie Que	20 hours	50 residents monthly		Yes, attached
On-site health provider with a private room				
Name of health care provider	Number of hours the service provider is on site per month	Number of residents utilizing services in a month (on average)	*What documentation is included as an attachment?*	
County Health Services	3 hours per month (one visit)	15-20 residents	*e.g. Sign-in sheet or log from provider*	
Other Services Provided (i.e., On-site Pharmacy, Wellness Clinic, Satellite Hospital Office, PACE program, Assisted Living Program (ALP), Medical Day Care Program Licensed Assisted Living Facility or Other Similar Programs)				
Indicate which service is being provided	Name of service provider	Number of hours service provider is onsite per week	Number of residents served in a month (on average)	*What documentation is included as an attachment?*
Wellness Clinic	CVS Wellness Clinic	3 hours per month (one visit)	15-20 residents	*e.g. Sign-in sheet or log from provider*
Accessible outdoor spaces				
What outdoor spaces are being used and how by tenants				

Description from Floor plan that shows BBQ pits, smoke area and picnic seating areas
Exercise Room
Indicate how this room is being used on a monthly basis
Space for yoga, chair aerobics and meditation classes and a small gym with weights and tread mill

OWNER CERTIFICATION

By signing this form, the Owner is confirming the social services committed to at the time of the LIHTC application are being provided to residents of this property.

Owner's Signature: ___ *Barbara Power*_ ___ Date: __ Month, Day, Year _____

Owner's Name: ___ Barbara Power __

Owner's Title: ___ Director _____