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 <u>Compliance Monitoring Manual</u> 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 Participation in the | 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? |
| Name of SIL Coordinator | Numbers of hours per week onsite | Number of residents month (on average) | utilizing services in a | SIL Coordinator job description is included as documentation, in addition to this completed form |

| On-site health provi | der with a private | e room | | |
|-----------------------|--------------------|---------------------|-------------------------------|---------------------------|
| Name of health | Number of | Number of | What documentation | is included as an |
| care provider | hours service | residents utilizing | attachm | ent? |
| | provider is on | services in a month | | |
| | site per month | (on average) | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | e, PACE program, Assisted |
| | - | _ | sisted Living Facility or Oth | |
| Indicate which | Name of | Number of hours | Number of residents | What documentation is |
| service is being | service | service provider is | served in a month (on | included as an |
| provided | provider | onsite per week | average) | attachment? |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Accessible outdoor s | spaces | | | |
| What outdoor space | s are being used a | nd how by tenants | | |
| | | | | |
| | | | | |
| | | | | |
| Exercise Room | | | | |
| Indicate how this roo | om is being used o | 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

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 <u>Compliance Monitoring Manual</u> 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.

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

REVIEW FORM FOR PROJECTS IN THE AGE-FRIENDLY SENIOR CYCLE

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 | | 1 | | 1 |
| Name of SIL | Numbers of | Number of residents | utilizing services | SIL Coordinator |
| Coordinator | hours per | in a month (on average | ge) | job description |
| | week onsite | | | is included as |
| | | | | documentation, |
| | | | | in addition to |
| | | | | this completed |
| | | | | form |
| Suzie Que | 20 hours | 50 residents monthly | | Yes, attached |
| Suzie Que | 20 110015 | 50 residents monthly | | Tes, attached |
| On-site health pro | ovider with a priva | ate room | | P |
| Name of health | Number of | Number of residents | What documen | tation is included |
| care provider | hours the | utilizing services in a | as an attachme | nt? |
| - | service | month (on average) | | |
| | provider is on | | | |
| | site p <mark>er month</mark> | | | |
| County Health | 3 hours per | 15-20 residents | e.g. Sign-in shee | et or log from |
| Services | month (one | | provider | |
| | visit) | | | |
| | | | | |
| Other Services Pr | ovided (i.e., On-sit | e Pharmacy, Wellness | L Clinic, Satellite Ho | ospital Office, |
| | | L ce Pharmacy, Wellness ram (ALP), Medical Day | | the second s |
| PACE program, As | | am (ALP), Medical Day | | the second s |
| PACE program, As | sisted Living Prog | am (ALP), Medical Day | | the second s |
| PACE program, As | sisted Living Prog | am (ALP), Medical Day | | the second s |
| PACE program, As Living Facility or C | ssisted Living Progr Other Similar Progr | ram (ALP), Medical Day ams) | Care Program Lic | censed Assisted |
| PACE program, As Living Facility or C Indicate which | Ssisted Living Progr Other Similar Progr Name of | ams) Number of hours | Care Program Lic | what |
| PACE program, As Living Facility or C Indicate which service is being | Sisted Living Progr Other Similar Progr Name of service | ALP), Medical Day ams) Number of hours service provider is | Care Program Lic Number of residents | What documentation |
| PACE program, As Living Facility or C Indicate which service is being | Sisted Living Progr Other Similar Progr Name of service | ALP), Medical Day ams) Number of hours service provider is | Care Program Lic Number of residents served in a | What documentation is included as an |
| PACE program, As Living Facility or C Indicate which service is being | Sisted Living Progr Other Similar Progr Name of service | ALP), Medical Day ams) Number of hours service provider is | Care Program Lic Number of residents served in a month (on | What documentation is included as an |
| PACE program, As Living Facility or C Indicate which service is being | Name of provider | ALP), Medical Day ams) Number of hours service provider is onsite per week | Care Program Lic Number of residents served in a month (on average) | What documentation is included as an attachment? |
| PACE program, As Living Facility or C Indicate which service is being provided | Name of service provider CVS Wellness | ALP), Medical Day ams) Number of hours service provider is onsite per week 3 hours per month | Care Program Lic Number of residents served in a month (on average) 15-20 | What documentation is included as an attachment? e.g. Sign-in |
| PACE program, As Living Facility or C Indicate which service is being provided Wellness Clinic | Name of service provider CVS Wellness Clinic | ALP), Medical Day ams) Number of hours service provider is onsite per week 3 hours per month | Care Program Lic Number of residents served in a month (on average) 15-20 | What documentation is included as an attachment? e.g. Sign-in sheet or log |
| PACE program, As Living Facility or O Indicate which service is being provided Wellness Clinic Accessible outdoo | Name of service provider CVS Wellness Clinic | ALP), Medical Day ams) Number of hours service provider is onsite per week 3 hours per month | Care Program Lic Number of residents served in a month (on average) 15-20 | What documentation is included as an attachment? e.g. Sign-in sheet or log |

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: <u>Barbara Power</u> Owner's Title: <u>Director</u>