Leisure Town Home Association
100 Sequoia Drive, Vacaville, California 95687

AGE RESTRICTED COMMUNITY CENSUS FORM
MUST BE RETURNED BY JULY 30TH, 2022

Please take the time to fill out this census form and mail the completed form to the above address. It is necessary for the Leisure Town Home Association (the "Association") to maintain current information for compliance with state and federal age-restriction laws as the Association is an age-restricted community. Under the applicable state and federal laws, residency in the Association is generally restricted to persons fifty-five (55) years of age or older. This information will be kept for purposes of ensuring that the community follows the age-qualification requirements under state and federal law to protect the age-restricted status of our community.

A. General Information

Name of Owner(s): _____

Unit Address: _____

Mailing Address: _____

Telephone: _____

Does the Owner(s) (check one):

☐ Reside in the unit
-OR-
☐ Rent the unit

B. Specific Questions Relating to Occupancy of the Unit

Please read the following disclosure prior to answering the questions below. For each occupant living in the above stated unit, please list their name and age below and indicate how they qualify to be a resident. To qualify to be a resident, each occupant must fit into one of these three categories. Any individual who fails to qualify under one of three categories may only reside within the residence as a guest of the occupants for no more than sixty (60) days per calendar year.

1. ***Qualifying Resident***: An individual 55 years or older who resides in the community as their primary residence.

2. ***Qualified Permanent Resident***:

   (a) An individual who resides with a Qualifying Resident (a person who is 55 years or older) prior to his or her death, hospitalization, other prolonged absence, or the dissolution of marriage and is 45 years or older or the spouse, co-habitant, or person providing physical or economic support to the Qualifying Resident.
   -OR-
   (b) An individual who is the adult child or grandchild of a Qualifying Resident or Qualified Permanent Resident and who has a disabling condition, illness, or injury as defined as having a record of physical or mental impairment that substantially limits one or more major life activities.

3. ***Permitted Health Care Resident***: An individual hired or a family member who provides live-in, long-term, or terminal health care to a Qualifying Resident.

C. **Occupant Information***

1. Name of Occupant: _____
   Age of Occupant: _____ years old

   Occupant Qualifies as (*please check only one per occupant):*

   ☐ *Qualifying Resident*
   ☐ *Qualified Permanent Resident*
   ☐ *Permitted Health Care Resident***

2. Name of Occupant: _____
   Age of Occupant: _____ years old

   Occupant Qualifies as (please check only one per occupant):

   ☐ *Qualifying Resident*
   ☐ *Qualified Permanent Resident*
   ☐ *Permitted Health Care Resident***

3. Name of Occupant: _____
   Age of Occupant: _____ years old

   Occupant Qualifies as (*please check only one per occupant):*

   ☐ *Qualifying Resident*
   ☐ *Qualified Permanent Resident*
   ☐ *Permitted Health Care Resident***

4. Name of Occupant: _____
   Age of Occupant: _____ years old

   Occupant Qualifies as (*please check only one per occupant):*

   ☐ *Qualifying Resident*
   ☐ *Qualified Permanent Resident*
   ☐ *Permitted Health Care Resident***

***PLEASE USE ADDITIONAL PAGES IF NECESSARY.**

****PLEASE COMPLETE AND RETURN DECLARATION OF PERMITTED HEALTH CARE RESIDENT**

Leisure Town Home Association
100 Sequoia Drive, Vacaville, California 95687

DECLARATION OF PERMITTED HEALTH CARE RESIDENT

I, by my signature below, hereby attest to the following:

1. I understand that the Association is an age-restricted community and that in accordance with state and federal laws, residency in the Association is generally restricted to persons fifty-five (55) years of age or older ("Qualifying Resident").

2. I have informed the Association that I qualify for an exception from the age-restriction requirements as a Permitted Health Care Resident to _____ [print name of Qualifying Resident], who is age-qualified. I understand that in accordance with California law, a Permitted Health Care Resident is "a person hired to provide live-in, long-term or terminal healthcare to a qualifying resident, or a family member of the qualifying resident providing that care." I also understand that under California law, the care I provide must be substantial in nature and must aid with necessary daily activities, medical treatment, or both.

3. I understand that I may continue my residency in the absence of the Qualifying Resident for a period of ninety (90) days in the event that: (a) the Qualifying Resident becomes absent due to hospitalization or other necessary medical treatment and expects to return within that ninety (90) day period, and (b) the Qualifying Resident or person legally authorized to act on his or her behalf provides the Board of Directors with written notice consenting to such occupancy in his or her absence. If the Qualifying Resident gives further written consent, I may be authorized to stay for an additional ninety (90) days, if it appears that the Qualifying Resident will return to the residence within ninety (90) days.

4. Except as otherwise stated in paragraph 3, above, I understand that I may only continue to reside in the Association if I continue to provide the Qualifying Resident with live-in, long-term, or hospice healthcare for compensation. I agree to notify the Association if the Qualifying Resident no longer requires my help (*e.g*. she or he moves to a nursing home permanently or passes away), and understand that I will be required to move unless I have myself become age-qualified (i.e. 55 years of age or older) at that time.

5. I verify that I am being compensated for my health care services to the Qualifying Resident in the form of (check all that apply):

- ☐ monetary compensation
- ☐ food and lodging
- ☐ family member
- ☐ other (describe) _____

6. I understand that the Board of Directors will review my status as a Permitted Health Care Resident. By my signature below, I agree to assist the Board in whatever manner as the Board may deem necessary to verify my continuing health care services as a Permitted Health Care Resident.

Signature of Permitted Health Care Resident

DATED: _____, 20___

SIGNATURE: _____

PRINT NAME: _____