CSP#______________________________

Unified Supportive Housing System (USHS)
Prospective Applicant File Checklist

Use the following checklist to ensure that all necessary documentation has been included before submission. The contents of this file are valid for 180 days from Prospective Applicant signature date.

❑ Release of Information (ROI)
❑ Demographics Form
❑ Certification of Disabling Condition (provide one of the following):

> ❑ Written verification from a professional who is licensed by the state to diagnose and treat that condition, stating that the disability is expected to be long-continuing or of indefinite duration and that the disability substantially impedes the individual's ability to live independently. (Certification Of Disability [COD])
> ❑ Written verification from the Social Security Administration (SSA).
> ❑ Copy of a disability check from SSA or the U.S. Department of Veteran Affairs.

❑ Income Verification (Documentation of Income or Zero Income Statement)
❑ Verification of Identity and Citizenship for every member of the household. (Legible and clear copies only):

> ❑ Social Security card or verification of SSN printout from Social Security Administration.
> ❑ Original birth certificate or letter/form requesting birth certificate.
> ❑ Current State of Ohio issued photo ID or Driver's License with Franklin County address. [Not required for minors under the age of 18]
> ❑ Name on Social Security documentation, birth certificate and photo ID match or verification of legal name change included

❑ Documentation of Homelessness (CSP Printout and/or Street Homeless Verification Form or Homeless Verification for client residing at CHOICES)
❑ Unit Specific Documentation for Veteran's and Family Units (If applicable)

By signing below I assert that I believe this applicant can benefit from Permanent Supportive Housing due to a long history of homelessness and the presence of a disabling condition that impedes independent living. I further assert that I have personally examined all documentation. To my knowledge all information contained herein, is accurate, truthful and complete.

Provider Agency Rep.	Printed Name	Signature	Date

CSP#_______________

Unified Supportive Housing System (USHS)
Authorization for Release of Information

Prospective Applicant Name: ____

The Unified Supportive Housing System (USHS) Prospective Applicant File collects information, which helps to determine preliminary eligibility for housing and community supports to assist with housing stability. USHS also requires additional information to be provided by other government agencies and service providers. In order for USHS to collect the information and process the form, your consent to release information is required.

I. USHS understands that information about you, your health, employment/income, and housing history are personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before using or disclosing your protected health and personal information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

II. Purpose: Provider Agency (name of agency assisting Prospective Applicant to complete this form) ____, Unified Supportive Housing System, Alcohol Drug and Mental Health Board (ADAMH), Community Shelter Board (CSB), Franklin County Children Services (FCCS), and the following housing providers: Alvis, Equitas, Community Housing Network (CHN), Maryhaven, National Church Residences (N^^), Volunteers of America of Greater Ohio (VOAGO), YMCA, and YWCA may use this authorization and the information obtained with it, to collect and share with agencies named above, the information about my household members and me outlined in Part III below. The purpose of collecting and sharing information is to determine preliminary eligibility for supportive housing.

III. Authorization: For a period of six months from the date of my signature below, I authorize the above named organizations to obtain information about me or my family that is pertinent to my USHS file.

IV. Information Covered-Inquiries may be made about: Physical and Mental Health records, Substance Abuse Treatment records, Child Care Expenses, Handicapped Assistance Expenses, Credit History, Identity and Marital Status, Criminal Activity, Medical Expenses, Family Composition, Social Security Numbers, Federal/State/Tribal/Local Benefits, Residences and Rental History, Homeless History, History with FCCS, Columbus Metropolitan Housing Authority (CMHA), ADAMH (current and previous service utilization and linkage with ADAMH Provider Agencies), CSB programs, and Employment/Income/ Pensions/Assets.

V. Individuals/Organizations that may Release Information: Any individual or organization including any governmental organization may be asked to release information. For example, information may be requested from: ADAMH, CMHA, CSB, FCCS, housing providers mentioned in Section I above, Banks and Financial Institutions, Utility Companies, Landlords, Employers – Present and Past, Courts, U.S. Dept. of Veterans Affairs, Welfare Agencies, Law Enforcement Agencies, Credit Bureaus, Schools or Colleges, U.S. Social Security Administration, Providers of: Alimony, Substance Abuse services, Case Management services, Child Care, Child Support, Credit, Handicapped Assistance, Medical Care (including mental health services), Pensions/Annuities, Emergency Shelters and Housing Services.

VI. **Minor Children:** If I am a custodial parent of a minor child, I also give my authorization for the following children:

First Name	Middle Name	Last Name	Date of Birth

VII. **Revocation:** I understand that I have the right to revoke this authorization at any time by notifying the USHS Project Manager in writing at: 111 Liberty St., Suite 150, Columbus, OH 43215. I understand that the revocation is only effective after it is received and logged by USHS. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation and the revocation will not apply to disclosures made in reliance on the authorization. I understand that after the information is disclosed, federal or state law might not protect it, and the recipient might re-disclose it.

VIII. **Database Matching Notice /Consent:** I agree that the above named organizations using my information can conduct computer matching with other government agencies including Federal, State, Tribal or Local agencies. The government agencies include: Ohio Departments of Mental Health, Alcohol and Drug Addiction Services, Job and Family Services, U.S. Office of Personnel Management, U.S. Social Security Administration, State Employment Security Agencies, and State Welfare and Food Stamp Agencies.

IX. I also agree that the above named organizations may enter personal information on members of my household and me and may research my information in Columbus ServicePoint (CSP), the database which is used by agencies providing shelter and housing-related services in Franklin County, MACSIS, the database which is used by agencies in the Mental Health system and SHARES, the database which is used by agencies funded by the Alcohol, Drug and Mental Health Board of Franklin County.

X. **Conditions:** I agree that photocopies of this authorization may be used for the purposes stated above. If I do not sign this authorization or if I sign this authorization and later revoke it, I

understand that my USHS file will not be processed. This release of information is valid for six months from the date of signing.

____ ____________________

Signature, Head of Household Date

For USHS Use Only
Rcvd By_______________________________________ Date of Revocation: __________

CSP#________________

❑ Homeless ❑ Non-Homeless ADAMH Client Non-Homeless VHA Eligible VET N^^ MED/Choice

Unified Supportive Housing System (USHS) Prospective Applicant Demographics		
Name:		
Alias/Maiden Name:		
Date of Birth:		
Social Security Number:		
Phone Number:		
Provider Name:		
Provider Email:	**Provider Phone:**	
Race (Voluntary):		
❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American	❑ Native Hawaiian/Other Pacific Islander ❑ White ❑Other____________________	
Ethnicity (Voluntary):		
❑ Hispanic/Latino	❑ Non-Hispanic/Latino	
Are You a US Citizen or Legal US Resident?		
❑ Yes ❑ No		
Gender Identity:		
❑ Male ❑ Female	❑ Trans Female (MTF or Male to Female) ❑ Trans Male (FTM or Female to Male)	❑ Gender Non-Conforming ❑ Other ________________________
Are You Currently Pregnant?	If yes, which trimester?	
❑ Yes ❑ No ❑ N/A	❑ 1st (1-3 months) ❑ 2nd (4-6 months) ❑ 3rd (7-9 months)	

Are You a Fulltime Student?		
❑ Yes ❑ No		
Do You Have a Legal Guardian?		
❑ Yes ❑ No		
Do You Currently Have a Payee?		
❑ Yes ❑ No		
Are you Able to Turn on Utilities (i.e. gas, water, electricity) in Your Name?		
❑ Yes ❑ No		
Do You Owe Any Money to a Utility Company?		
❑ Yes ❑ No If Yes, which utlity(ies):_______________________________		
Do You or a Member of Your Family Require Special Accommodations?	If yes, please check yes and below which accommodation(s) you need:	
❑ Yes ❑ No	❑ Wheelchair accessible ❑ No steps ❑ Few steps ❑ Handicap accessible parking	❑ Hearing disability ❑ Grab bars and handrails ❑ Modification for vision or hearing impairment
Total Monthly Income:	$	
Do You Receive Any of the Following: (Check all that Apply)		
❑ Alimony ❑ Child support ❑ Earned income ❑ General Assistance ❑ Pension or retirement income from another job	❑ Private disability insurance ❑ Retirement income from Social Security ❑ SSDI ❑ SSI ❑ TANF	❑ Unemployment Insurance ❑ VA Non-Service Connected Disability Pension ❑ VA Service Connected Disability Compensation ❑ Workers Compensation
Do You Have Any of the Following? (Check all that Apply)		
❑ Checking account ❑ Direct Express Account ❑ Life insurance	❑ Retirement ❑ Savings account ❑ SNAP (Food Stamps)	❑ TANF Child Care Services ❑ TANF Transportation Services ❑ WIC
Health Insurance Type: (Check all that Apply)		
❑ MEDICAID ❑ MEDICARE ❑ State Children's Health Insurance Program (SCHIP)	❑ VA Medical Services ❑ Employer-Provided Insurance ❑ Health Insurance obtained through COBRA	❑ Private Pay Health Insurance ❑ State Health Insurance for Adults ❑ Indian Health Services ❑ Not Covered

Do You Have one (1) or More Pets?	If yes, what type of animal is it?	Is your pet a service or therapeutic animal?
❑ Yes ❑ No	❑ Cat ❑ Dog ❑ Other	❑ Yes ❑ No
Are You Currently Linked to a Mental Health Provider?	❑ Yes* ❑ No	***If yes, please give that Agency's Name Below:** ______________________
Mental Health Case Manager Name (If Applicable)		
Are You a person Who Served at Least One Day of Active Military, Naval, or Air Service and Who was Discharged or Released Under Conditions Other Than Dishonorable?		
❑ Yes ❑ No		
Prospective Applicant's Current Living Arrangement:		
<u>HOMELESS SITUATION</u> ❑ Place not meant for habitation ❑ Emergency shelter (including, CHOICES for Victims of Domestic Violence)	<u>INSTITUTIONAL SETTING</u> ❑ Foster care home or foster care group home ❑ Hospital or other residential non-psychiatric medical facilities ❑ Jail, prison or juvenile detention facility ❑ Long-term care facility or nursing home ❑ Psychiatric hospital or other psychiatric facility ❑ Substance abuse treatment facility or detox center	<u>TRANSITIONAL AND PERMANENT HOUSING SITUATION</u> ❑ Residence owned ❑ Rental without subsidy ❑ Permanent housing (other than RRH) for formerly homeless persons ❑ Rental by client with other ongoing housing subsidy (including RRH) ❑ Transitional housing for homeless persons (including homeless youth)
Will There be Another Adult Residing with You in the Household?	❑ Yes* ❑ No	***If yes, please Give that Person's Name Below:** ______________________
Do Currently Have Legal Custody of Any Minor Children?		
❑ Yes* ❑ No	*If so, please ensure that minor children are on the Release of Information Form.	

***Please Note:** All prospective applicants are given two (2) opportunities to accept a housing unit that is not substandard housing for any reason. Prospective applicants are expected to tour unit/housing property prior to refusal. Refusal to accept a safe, decent, affordable housing option twice will result in the individual being ineligible for Housing through Unified Supportive Housing System (USHS) for one (1) calendar year.

I understand that open criminal cases or active warrants may delay processing of my file for housing access. Past criminal background will be reviewed and may affect my eligibility for housing within the USHS, based on restrictions in place at different housing sites. These restrictions are based on federal, state or local requirements that the USHS is not in control of.

I understand that my completion of this form does not guarantee housing in the Unified Supportive Housing System. I further understand that my case worker should continue to assist me in finding an appropriate living situation. I certify, under penalty of law, that the above information provided by me on this form is true and complete to the best of my knowledge and ability.

______________________________ ______________________

Signature, Prospective Applicant Date

Provider Agency Use Only

[Not for Diagnostic Purposes]

The Prospective Applicant has a "disabling condition" meaning they have:

- A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:
  1) Is expected to be long-continuing or of indefinite duration;
  2) Substantially impedes the individual's ability to live independently; and
  3) Could be improved by the provision of more suitable housing conditions.
- A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or
- The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

(Check All That Apply to Ensure Appropriate Placement)

Mental or Emotional Impairment
❑ Yes ❑ No

Physical Impairment
❑ Yes ❑ No

Alcohol or Drug Abuse
❑ Yes ❑ No

Post-traumatic Stress Disorder
❑ Yes ❑ No

Brain Injury
❑ Yes ❑ No

Developmental Disability
❑ Yes ❑ No

Acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV)
❑ Yes ❑ No

______________________________ ______________________

Signature, Provider Agency Representative Date

______________________________ ______________________

Printed Name Provider Agency Name

CSP#_______________

Certification of Disability

An individual with a "disabling condition" has one or more of the following:

- A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:
  1) Is expected to be long-continuing or of indefinite duration;
  2) Substantially impedes the individual's ability to live independently; and
  3) Could be improved by the provision of more suitable housing conditions.

- A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or

- The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

I have read the above definition of "disabling condition" and I hereby certify that
____ has a disabling condition.

I further certify that I am a professional licensed by the state to diagnose AND treat the disability and that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently.

❑ Physician ❑ LPCC
❑ CNP ❑ PCC
❑ CNS ❑ LICDC
❑ LISW

____
Authorized Signature Date

____
Printed Name

Unified Supportive Housing System (USHS)
Declaration of Zero Income

I ______________________________________, understand that the information provided on this form will be used to determine income eligibility. I have read the clarification for what is considered income* and hereby certify that I am currently receiving no income from any source.

I certify that this statement is true to the best of my knowledge and understand providing false, misleading or incorrect information may result in ineligibility for Housing Provider units in the Unified Supportive Housing System (USHS).

________________________________ ____________________
Prospective Applicant Signature ** Date

________________________________ ____________________
Provider Agency Representative Date

*Income: *Wages from job, self-employment, Social Security, Social Security Income (SSI), Pension/Veteran's Administration (Military Pay), TANF/Ohio Works First (Public Assistance), Unemployment Benefits, Workers Compensation, Educational Financial Assistance (Financial Aid), Court-Ordered Child Support Payments Received, Informal Child Support Payments Received and Alimony.*

***Document is valid for* thirty (30) days *from the signature date. Upon referral Housing Provider will ask for updated income verification.*

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Please include: Income documentation if client did not complete the zero income statement.

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Please include for every household member:

(1) Social security card or SSN printout
2) Birth Certificate or copy of request for Birth Certificate; Passport is also acceptable.
(3) Current State of Ohio issued photo id or Driver's License with Franklin County, Oh address (Not required for minors under the age of 18)

*Please verify that all names match across documentation, if not please provide documentation of legal name change.

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Please Include: Documentation of Homelessness:
(1) Columbus ServicePoint (CSP) Entry/Exit Record and/or
(2) Verification of Street Homelessness Form, or
(3) Letter from Choices for Victims of Domestic Violence.

Please Include: Documentation of Institutional Stay of Less Than 90 Days (if homeless immediately prior to entry) if attempting to count stay towards homeless time

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For Prospective Applicants with **minor children** please include:
(1) Copy of the JFS “Proof of Eligibility” Printout,
(2) Court Documentation of Custody, or
(3) Custody/Guardianship documentation from Franklin County Children Services

For **VHA eligible** Prospective Applicants please include: Documentation of Veteran status (DD-214/215, NGB 22/22A or VA ID).