Applicant Name: _____ **Referral Contact:** _____

DEL-MOR DWELLINGS

Housing Solutions Supporting Mental Health

Independent Supportive Housing Referral
Required Documentation Checklist

- ☐ Del-Mor Dwellings Housing Referral Form
- ☐ Certification of Psychiatric Disability Form
- ☐ Release of Information for Mental Health Treatment Provider
- ☐ Income Documentation
  - ☐ SSI/SSDI Award Letters or 6 weeks of paystubs/JFS child support payments, etc.
  - ☐ If you are reporting zero income, please sign the Certification of Zero Income Form included. If applicable, attach proof of your pending SSI/SSDI claim.
- ☐ Section 8 | Metropolitan Housing Waitlist Status
- ☐ Copy of Photo ID
- ☐ Copy of Social Security Card

OFFICE USE ONLY:

Date Application Received: _____

Time Application Received: _____

DEL-MOR DWELLINGS, CORP.

110 Courage Court, Unit E
DELAWARE, OHIO 43015
PH: (740) 363-5562, Fax: (740) 957-8211

Dear Housing Applicant,

Enclosed is the Del-Mor Dwellings Supportive Housing Referral. The required items you will need to submit along with this completed referral packet are listed for you on the first page titled, *"Housing Referral Documentation Checklist"*.

Please note that you will need an independently licensed mental health professional or a physician to complete the "Certification of Psychiatric Disability Form" which is included in this packet. Due to our agency's mission to provide safe, decent, and affordable independent housing to those with disabling mental illness, this completed certification is required and serves as a primary eligibility factor to your housing application. You will also need to complete the enclosed *"Authorization to Exchange Information"* form for the independently licensed provider who signed the certification.

We ask that you collect and provide copies of all of your current source(s) of monthly income (e.g., Social Security Award Letter, Paystubs, Child Support, etc.). If you do not currently have a source of income and are awaiting a response from the Social Security Administration, please provide proof of your active claim and sign the enclosed *"Certification of Zero Income*" form.

In order to sustain our supportive housing services in the community, we require our applicants to complete a Section 8 Housing Choice Voucher application with their local Metropolitan Housing Authority office. If you are applying for our housing in Delaware County, please note that the Section 8 waitlist is currently closed and you are unable to apply at this time. We still ask that you read and sign our updated *"Section 8 Confirmation"* form that will provide us with information about your current Section 8 status, history, and willingness to apply when their waitlist reopens. For more information, you can go to http://www.delawaremha.org/.

Submitted applications must be complete or we will be unable to process them and add you to our waitlist. Please refer back to the document checklist to ensure you have included all items before submission. You can turn in your application by mail, by email at housingwaitlist@delmordwellings.org, or during standard business hours at our Downtown Delaware office located at 30 N. Franklin Street. Once we have received your application, a Resident Support Staff member will be in touch with you within 7-14 business days to learn more about your long-term housing needs and educate you about our waitlist process.

Sincerely,

Del-Mor Dwellings Corp.

DEL-MOR DWELLINGS, CORP.

110 Courage Court, Unit E
DELAWARE, OHIO 43015
PH: (740) 363-5562, Fax: (740) 957-8211

HOUSING REFERRAL FORM

Date: _____ Applicant Name: _____

Phone: _____ Email: _____

Address: _____
City State Zip Code

Referral Contact: _____ Agency: _____

Phone No: _____ Email: _____

Address: _____
City State Zip Code

1. HOUSEHOLD COMPOSITION (List all persons that will live with you on a full-time basis)

Name	Date of Birth	Social Security Number	Relationship to Head of Household	Gender
1			**Head**	
2				
3				
4				

2. RACE AND ETHNICITY (Select all that apply for each adult in the household)

Head of Household **Racial Categories**	**Select All That Apply**	**Second Adult** **Racial Categories**	**Select All That Apply**
American Indian or Alaska Native		American Indian or Alaska Native	
Asian		Asian	
Black or African American		Black or African American	
Native Hawaiian or Other Pacific Islander		Native Hawaiian or Other Pacific Islander	
White		White	
Other		Other	

3. PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

a. YES NO Is the person disabled by severe persistent mental illness? Please include the 'Certification of Disability' form.

b. YES NO Have you or any adult member in your household been hospitalized due to mental disability? If yes, please list the name and estimated dates of your past psychiatric hospitalizations below:

_____

_____

e. YES NO Does this person have a Legal Guardian? If yes, please list the name, contact, and provide proof of guardianship.

_____

f. YES NO Does this person have a Representative Payee? If yes, please list: _____

g. YES NO Has the person or a member in their household ever been evicted?

i. YES NO Does this person need a first-floor apartment or handicap-accessible unit? If yes, please explain reason for the Reasonable Accommodation request:

_____

j. YES NO Does this person have any outstanding balances owed to utility companies from previous properties?

j. YES NO Does this person have or plan to have an Emotional Support Animal (ESA)?

k. YES NO Has the person rented in the past two years? Please list all previous addresses and dates for the previous two years.

1. _____
Address Dates

Reason for leaving._____

2. _____
Address Dates

Reason for leaving. _____

3. _____
Address Dates

Reason for leaving. _____

2. EXPLAIN CURRENT HOUSING SITUATION. IF WITHOUT HOUSING, EXPLAIN WHY AND FOR HOW LONG:

_____

_____

_____

3. WHAT CHALLENGES DOES THIS PERSON ANTICIPATE IN SECURING HOUSING? PLEASE EXPLAIN:

_____

_____

_____

4. TOTAL HOUSEHOLD INCOME:

Does any adult in the household receive any of the following sources of income?

a. YES NO Wages from Employment (This includes any income earned by any family member 18 years or older). Please list all wage earners and their employers:

Name: _____ Employer: _____ Wages/Week: _____

Name: _____ Employer: _____ Wages/Week: _____

b. YES NO Social Security, SSI, or SSDI payments received by adults for all adults or dependents? (If you are receiving Social Security Benefits from a Spouse, please indicate the correct Social Security Number under which you receive these benefits)

Name: _____ Soc. Sec. No. _____Mo. Benefit Amount: _____

Name: _____ Soc. Sec. No. _____Mo. Benefit Amount: _____

c. YES NO Is there a pending application for SSI/SSDI? Include supporting documentation.

d. YES NO Veteran's Administration Benefits:

Name: _____ Claim No. _____ Mo. Benefit Amount: _____

e. YES NO Welfare Assistance, Unemployment, annuities, dividends, interest from insurance policies, retirement benefits, pensions, disability, worker's compensation, severance pay, death benefits, and other similar types of periodic income? If yes, please list:

Source: _____ Amount: _____per _____(week/month/year)

Source: _____ Amount: _____per _____(week/month/year)

Source: _____ Amount: _____per _____(week/month/year)

f. YES NO Child Support and/or Alimony. If yes, list amount: _____ (circle: weekly/monthly)

List **all** counties you receive child support or alimony from: _____

5. MEDICAL EXPENDITURES: Please circle yes or no to the following questions:

YES NO Do you anticipate medical/prescription drug expenses that will not be covered by insurance for the next twelve (12) months? If yes, list to whom they will be owed and estimate the amount not covered by insurance.

Name: _____ Address: _____ Amount: _____

Name: _____ Address: _____ Amount: _____

6. CRIMINAL ACTIVITY

YES NO Have you or anyone in your household been arrested and/or convicted of any drug related activity or criminal activity? If yes, please give details of your arrest and/or conviction:

_____

_____

7. <u>CERTIFICATION OF INFORMATION:</u>

I/we hereby certify and attest that all of the information given above about myself and all members of my/our household is complete, true, and correct to the best of my/our knowledge.

_____		_____	
Head of Household	Date	Spouse	Date
_____		_____	
Other Adult	Date	Other Adult	Date

If you were unable to fill out this form in your own handwriting, please have the person assisting you sign their name below:

_____	_____
Name	Relationship to Applicant

CERTIFICATION OF PSYCHIATRIC DISABILITY

The purpose of this certification form is to verify that the applicant meets the eligibility criteria for our publically funded non-for-profit supportive housing agency. Our mission serves to provide safe, decent, and affordable housing to residents of Delaware, Morrow, and Crawford County disabled by a severe, persistent mental illness.

I _____ hereby consent to the release of requested information Pertaining to my mental health condition as stated above by the Licensed Mental Health Care Professional named below.

_____ _____
Applicant's Signature Date

I hereby certify that based on diagnostic assessment and official diagnosis, the individual named above is, by clinical definition, disabled by a severe persistent mental health disorder.

_____ _____
Name of Physician or Independently Licensed Mental Health Care Professional

Signature of Physician or Independently Licensed Licensed Mental Health Care Professional

_____ _____
Name of Health Care Agency Date

Penalties for misusing this consent: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA, and any owner (or any employee of HUD, the PHA, or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person, who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA, or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42 U.S.C. 208(f) (g) and (h). Violations of these provisions are cited as violations of 42 U.S.C. 408 (f) (g) and (h).

AUTHORIZATION TO EXCHANGE PROTECTED INFORMATION
DEL-MOR DWELLING CORP.

110 Courage Court, Unit E Delaware, Ohio 43015
Phone: (740) 363-5562 FAX: (740) 957-8211

NOTICE- PLEASE READ. I understand that this authorization will remain in effect for **2 years** from the date of signing. This authorization may be withdrawn at any time upon your request by signing the written revocation clause at the bottom of the form. Upon receiving your revocation signature, this release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that Del-Mor Dwellings Corp. will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

I, _____ **hereby voluntarily authorize Del-Mor Dwellings Corp. to exchange information with:**

_____
Name of Person or Entity:

_____
Address

_____
City/State/Zip Code

_____
Phone

Information to be used/exchanged: Mental health diagnosis, certification of disability, treatment plan and treatment coordination and participation.

The purpose of authorization: To obtain or maintain independent supportive housing and encourage successful tenancy.

I understand that I may withdraw this consent at any time in the future and that this authorization will expire in **2 years** from the date signed below, unless otherwise specified.

Signature: _____ Witness Signature: _____

Relationship: _____ Date: _____

Date:_____

NOTICE OF REVOCATION

I hereby, revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Signature: _____ Date Revoked: _____

DEL-MOR DWELLINGS, CORP.
110 Courage Court, Unit E
DELAWARE, OHIO 43015
PH: (740) 363-5562 Fax: (740) 957-8211

METROPOLITAN HOUSING AUTHORITY | SECTION 8 APPLICATION STATUS & RELEASE OF INFORMATION FORM

This is to confirm that _____ has applied for housing assistance
[Applicant's name]

with the _____ Metropolitan Housing Authority on _____.
[Name of County] *[Date Applied for Section 8]*

****

If Metropolitan Housing Waitlist is closed during the time of your Del-Mor Housing application, please leave the above section blank and complete the below section.

This is to confirm that _____ is willing and able to apply for housing assistance
[Applicant's name]

with the _____ Metropolitan Housing Authority when the waitlist reopens.
[Name of County]

****

I authorize the above Housing Authority to notify Del-Mor Dwellings when rent assistance for me becomes available. I agree this authorization is effective as long as my name remains on the Del-Mor Housing and Metro Housing waitlist, or until such time that I request the authorization be revoked, in which case Del-Mor Dwellings may be informed of such revocation.

_____ _____
Applicant Signature **Date**

****

FOR METRO HOUSING AUTHORIZED OFFICIALS ONLY:
We agree to provide additional notice of Section 8 voucher availability for the above person to Del-Mor Dwellings, as authorized by the applicant herein, in order to assure that the applicant is supported in making use of the available rent assistance.

_____ _____
Signature of Authorized Official
Metropolitan Housing Authority

Date of Application & Waitlist Number
Metropolitan Housing Authority

DEL-MOR DWELLINGS, CORP.

110 Courage Court, Unit E
DELAWARE, OHIO 43015
PH: (740) 363-5562 Fax: (740) 972-8211

CERTIFICATION OF ZERO INCOME

I,_____ hereby certify that I am, at this time, unemployed and that I have NO INCOME, or income that is less than $1,200 per year.

In the event that there is a change in my annual income, I understand that I am to notify Del-Mor Dwellings and provide documentation of my change in total household income.

I understand that once housed with Del-Mor Dwellings, the failure to report changes in my household income or the size of my family composition within a 14 calendar day period of the change will put me in violation of my lease agreement and could result in the termination of my rental assistance.

I have also been informed that during the time that my income is zero or my annual income is less than $1,200 per year, I am required to participate in interim meetings with Del-Mor Support Staff to review efforts made to secure monthly income and complete recertification paperwork for the rental subsidy I receive.

By signing this form, I certify my understanding of the responsibilities in reporting changes to my income and my household composition while receiving rental assistance from Del-Mor Dwellings.

_____ _____
Head of Household Date