DEL-MOR DWELLINGS, CORP.
118 Stover Dr. Suite A
Delaware, OH 43015
PH: (740) 363-5562

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 second page titled, "*Required Documentation Checklist*".

Submitted screenings must be complete or we will be unable to process them and review your information. Please refer to the document checklist to ensure you have included all items. You can turn in your packet by mail or email at housingwaitlist@delmordwellings.org. Once we have received your completed screening, a Resident Support staff member will contact you about the waitlist process and your housing needs.

Sincerely,

Del-Mor Dwellings Corp.

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



Independent Supportive Housing Screening

Required Documentation Checklist

- ☐ Del-Mor Dwellings Housing Screening Form
- ☐ Certification of Psychiatric Disability Form
- ☐ Release of Information for your Mental Health Treatment Provider or the Referring Agency (if applicable)
- ☐ Income Documentation
  - ☐ SSI/SSDI Award Letters or 4-6 weeks of paystubs
  - ☐ If you are reporting zero income, please sign the Certification of Zero Income Form
- ☐ Copy of Photo ID
- ☐ Copy of Social Security Card
- ☐ FABCO Release
- ☐ Ohio DODD Individualized Service Plan, if applicable

OFFICE USE ONLY:

Date Application Received: _____

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

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PRELIMINARY HOUSING APPLICATION

Date: _____ Applicant Name: _____

Phone: _____ Email: _____

Address: _____

_____

City State Zip Code

Referral Contact: _____ Agency: _____

Phone Number: _____ Email: _____

Address: _____

_____

City State Zip Code

1. <u>HOUSEHOLD COMPOSITION</u> (List all persons that will live with you full-time)

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

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

2. Race (Mark one or more) **3. Ethnicity (select only one)**

Head of Household	Select All That Apply	Head of Household	Select One
African American		Hispanic or Latino	
American Indian or Alaska Native		Not Hispanic or Latino	
Asian			
Native Hawaiian or Other Pacific Islander			
White			
Other			

4. PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS

a. YES NO Does the applicant have a completed 'Certification of Disability' form?

b. YES NO Has the applicant or any adult member in the household been psychiatrically hospitalized? If yes, please list the name and estimated dates of the past hospitalizations below:

_____

_____

_____

c. YES NO Does the applicant have a Legal Guardian? If yes, please list the name, contact, and provide proof of guardianship:

_____

_____

d. YES NO Does the applicant have a Payee? If yes, list below:

_____

e. YES NO Has the applicant ever been evicted? If yes, please explain:

_____

_____

f. YES NO Does the applicant need a first-floor apartment or handicap-accessible unit? If yes, please explain:

_____

g. YES NO Does the applicant have an emotional support animal? Del-Mor allows one animal per ESA certification.

h. YES NO Has the applicant lived in another state over the past 5 years? If so, please list below:

1. _____

Address/City Dates

Reason for leaving: _____

2. _____

Address/City Dates

Reason for leaving: _____

3. _____

Address/City Dates

Reason for leaving: _____

i. YES NO Has the applicant or anyone in the household ever been convicted of a felony? If yes, please explain:

_____

_____

j. YES NO Has the applicant or anyone in the household ever been convicted of a misdemeanor? If yes, please explain:

_____

_____

k. YES NO Has the applicant or any member of the household been subject to a sex offender registration requirement in any state? If yes, please explain:

_____

_____

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

5. <u>HOW WOULD YOU DESCRIBE YOUR CURRENT LIVING SITUATION? :</u>

_____

_____

_____

6. <u>TOTAL HOUSEHOLD INCOME:</u>

Does any member 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 household earners.

Name: _____ Employer: _____

Name: _____ Employer: _____

b. YES NO Social Security, SSI, SSDI or VA payments received by adults for all adults or dependents?

Name: _____ Mo. Benefit Amount: _____

Name: _____ Mo. Benefit Amount: _____

c. YES NO Is there pending application for SSI/SSDI?

d. YES NO 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)

e. YES NO Child Support/Alimony? If yes, list monthly amount:_____

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

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

I/we hereby certify and attest that all 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. Failure to disclose accurate and complete information on this application may result in disqualification for Del-Mor Dwellings housing.

_____ _____

Head of Household Date Spouse/Other Adult Date

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

_____ _____

Signature Relationship to Applicant



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

CERTIFICATION OF PSYCHIATRIC DISABILITY

The purpose of this certification form is to verify that the applicant meets the eligibility criteria for our publicly 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 Mental Health Care Professional

_____ _____

Name of Health Care Agency Date

_____

DSM-5 or ICD-10 Codes

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).

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

AUTHORIZATION TO EXCHANGE PROTECTED INFORMATION

DEL-MOR DWELLINGS, CORP.

118 Stover Dr. Suite A
Delaware, OH 43015
PH: (740) 363-5562

NOTICE – PLEASE READ. I understand 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/or 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.

Signature: _____ Witness Signature: _____

Date: _____ Date: _____

NOTICE OF REVOCATION

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

Signature: _____ Date revoked: _____

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

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NOTICE- PLEASE READ. I understand that this authorization will remain in effect until a request for revocation is submitted. 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:

FABCO
4460 Executive Drive
Columbus, Ohio 43220

Information to be used/exchanged: **Background Check (criminal, credit, & rental history)**

The purpose of authorization: **Eligibility & selection criteria for acceptance into supportive housing**

I understand that I may withdraw this consent at any time in the future and that this authorization will not expire unless otherwise specified.

Signature: _____ Witness Signature: _____

Date: _____ Date: _____

NOTICE OF REVOCATION

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

Signature: _____ Date revoked: _____

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

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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.

If 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 complete recertification paperwork for the rental subsidy I receive, as requested.

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 Signature Date