HMIS ID#_____

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.

- ❑ Severity of Service Needs Assessment HMIS Submission
- ❑ Authorization for Release of Information
- ❑ Demographics
- ❑ Supportive Service Need Screening
- ❑ 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
- ❑ 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.
    - ❑ 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 (HMIS Printout and/or Street Homeless Verification Form or Homeless Verification Letter for client residing at CHOICES)
- ❑ Unit Specific Documentation for Veteran's and Family Units (If applicable). **See page 16 for specifics.**

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. I understand that all client's must be explicitly invited to submit by the USHS Program Manager unless they are documented HUD Chronically Homeless.

Provider Agency Rep.	Printed Name	Signature	Date

HMIS ID#_____

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 provider agencies: Community Housing Network (CHN), Equitas, Faith Mission (LSS), Home for Families (HFF), Homefull, Huckleberry House (Huck House), Maryhaven, National Church Residences (N^^), Southeast, The Salvation Army (TSA), Volunteers of America Ohio & Indiana (VOAOI), 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, CPO, Woda Cooper Companies, Inc., 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.

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

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: 355 East Campus View Blvd., Suite 250, Columbus, OH 43235. 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 Homeless Management Information System (HMIS ID), 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.

HMIS ID#_____

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

_____ _____

Signature, Head of Household **Date**

For USHS Use Only

Rcvd By_____ Date of Revocation: _____

HMIS ID#_____

Unified Supportive Housing System (USHS) Prospective Applicant Demographics	
Name:	
Alias/Maiden Name:	
Date of Birth:	
Social Security Number:	
Provider Name:	
Provider Email:	**Provider Phone:**

Are You a US Citizen or Legal US Resident?

❑ Yes ❑ No

What Gender Do You Identity With?

❑ Male
❑ Female
❑ Intersex
❑ Gender Non-Conforming/Non-Binary
❑ Other: _____
❑ Would rather not disclose

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 utility(ies): _____

HMIS ID#_____

Unified Supportive Housing System (USHS) Prospective Applicant Demographics		
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	❑ 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 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's 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		

HMIS ID#_____

Unified Supportive Housing System (USHS) Prospective Applicant Demographics		
Prospective Applicant's *Current* Living Arrangement:		
HOMELESS SITUATION ❑ Place not meant for habitation ❑ Emergency shelter (including, CHOICES for Victims of Domestic Violence)	INSTITUTIONAL SETTING ❑ 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	TRANSITIONAL AND PERMANENT HOUSING SITUATION ❑ 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 You Currently Have Legal Custody of Any Minor Children?		
❑ Yes* ❑ No	*If so, please ensure that minor children are on the Release of Information Form.	
Some Housing Projects Have Specific Subpopulations That They Are Required to Serve. This section is Only to Identify What Options You May be Eligible for. Please Check if You Meet One of the Following Criteria:		
❑ Mental or Emotional Impairment ❑ Alcohol or Drug Abuse ❑ AIDS/HIV+ ❑ Identify as Transgender		
Do you prefer a single site location (with staff onsite) or an apartment in the community? (Please note that this doesn't guarantee placement)		
❑ Single Site ❑ Scattered Site		
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	Place:	
	Time:	Or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	Phone:	
	Email:	

HMIS ID#_____

***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. Prospective Applicants can appeal USHS decisions.

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**

HMIS ID#_____

PLEASE CIRCLE YOUR CLIENT'S LEVEL OF SERVICE NEEDS IN EACH OF THE NEED DIMENSIONS

Need Dimension Based on *Recent* Client History	Service Need Level				
	1	2	3	4	5
Treatment participation	As scheduled for more than 3 months (or NA if no need)	As scheduled for less than 3 months	Requires help to maintain	Minimal	Refuses all
Medication Compliance	As scheduled for more than 3 months (or NA if no need)	As scheduled for less than 3 months	Requires help to maintain	Minimal	No compliance
Basic Needs: food, clothing, hygiene	Needs met for more than 3 months	Needs met for less than 3 months	Requires help to meet needs	Minimally met	Unmet
Benefits and Income Stream	Has income and has maintained it for more than 3 months	Has income and has maintained it for less than 3 months	Requires help to maintain	Applied for but not received	None; not applied for
Substance Abuse	None apparent for more than 3 months	None apparent for less than 3 months	Occasional minor impairment/abuse	Frequent minor impairment/abuse	Frequent major impairment/abuse
Danger to Self or Others	None apparent for more than 3 months	None apparent for less than three months	Possible	Probable	Imminent
Crisis Incidents	Limited or appropriately handled for more than 3 months	Limited or appropriately handled for less than 3 months	Intermittent crises, usually not appropriately handled	Frequent crises, usually not appropriately handled	Continual crises

Adapted from the DENVER ACUITY SCALE

USHS Use Only		
Score:		Potential Level of Case Management Need Upon PSH Placement
Very Low Intensity (1)		Self-Management, Monthly Face to Face Meetings
Low Intensity (2)		Monthly Face to Face Meetings
Medium Intensity (3)		Weekly Face to Face Meetings
High Intensity (4)		Daily or Multiple Weekly Face to Face Meetings
Severe Intensity (5)		May be Better Suited in a Higher Level of Care

HMIS ID#_____

REQUIRED

In your professional opinion, what have you learned about the client that impacts their ability to be housed?

_____ _____

Signature, Provider Agency Rep **Date**

HMIS ID#_____

COLUMBUS METROPOLITAN HOUSING AUTHORITY
COMMUNITY. COMMITMENT. COLLABORATION.

CERTIFICATION OF DISABLITY

"Persons with disabilities" is a household composed of one or more persons at least one of whom is an adult who has a disability.

1. A person shall be considered to have a disability if such person has a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such nature that such ability could be improved by more suitable housing conditions.

2. A person will also be considered to have a disability if he or she has a developmental disability, which is a severe, chronic disability that:

   (i) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

   (ii) Is manifested before the person attains age 22;

   (iii) Is likely to continue indefinitely;

   (iv) Results in substantial functional limitations in three or more of the following areas of major life activity;

      (A) Self-care
      (B) Receptive and expressive language;
      (C) Learning;
      (D) Mobility;
      (E) Self-direction;
      (F) Capacity for independent living; and
      (G) Economic self-sufficiency; and

   (v) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

3. A person is also considered disabled if they have the disease of acquired immunodeficiency syndrome (AIDS) and any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

Key to the definition is determining that the impairment is of long-continued and indefinite duration AND substantially impedes the person's ability to live independently.

I have read the above definition of "persons with disabilities" and I certify that

_____ is disabled. I further certify that I am authorized by the State of Ohio to make this determination.

_____

Authorized Healthcare Provider Date

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

HMIS ID#_____

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.*

This Page Intentionally Left Blank

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

This Page Intentionally Left Blank

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.

HMIS ID#_____

communityshelterboard
Until everyone has a place to call home

USHS INELIGIBILTY FORM

Additional Adult Name: _____ HMIS ID: _____

All adults in a household who are eligible for PSH must complete a separate Prospective Applicant File. In the case a household member decides to leave the initial PSH unit, he/she would need to prove eligibility for a unit transfer, if applicable, and/or the remaining member(s) would have to prove eligibility to remain in the current housing.

USHS Eligibility Requirements:

1. Prospective Applicant can provide documentation that he/she is disabled.
2. Prospective Applicant must have verification of identity and social security number.
3. Prospective Applicant must be a United States (U.S.) citizen or national or noncitizen with eligible immigration status in accordance with HUD Notice H-95-55.
4. Household income cannot exceed that of the HUD defined "extremely low income," 30% of AMI.
5. Prospective Applicant must be a resident of Franklin County, Ohio.
6. Prospective Applicant must be literally and verifiably homeless residing in emergency shelter, transitional housing (where they were homeless immediately prior to entry), or place not meant for human habitation.

I, _____, hereby state that **I do not meet all** of the above eligibility requirements for USHS prior to entry and acknowledge that I will not be eligible for PSH housing if I decide to leave the current household or if the qualifying member(s) of the household exits the program.

_____ _____
Head of Household Signature Date

_____ _____
Additional Adult Signature Date

This Page Intentionally Left Blank

Please Include: Documentation of Homelessness:
(1) Homeless Management Information System (HMIS) 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

This Page Intentionally Left Blank

For Prospective Applicants with **minor children** please include:
(1) Copy of the ODJFS "Proof of Eligibility" Printout,
(2) Court Documentation of Custody, or
(3) Copy of the minor child school records showing guardianship
(4) Head of Household may sign a sworn affidavit to attest the child is a member of the household

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