Housing Assistance Program Rental SubsidyApplication

Effective 4/2010

Please Check only one Program:

- ☐ Shelter Plus Care (SPC)
- ☐ Tenant Based Rental Assistance (TBRA)
- ☐ H-TBRA
- ☒ **Housing Assistance Program (HAP)**
- ☐ Housing Assistance Program/PATH Prison
- ☐ Supportive Housing Program - RR
- ☐ Supportive Housing Program - TASK
- ☐ Supportive Housing Program - MHS (specify site): ________
- ☐ Returning Home Ohio (RHO)
- ☐ SPC's Sponsor-based Rental Assistance (SRA) – not PSH
- ☐ Other (specify): ______________________________

***Applicant Information* (PLEASE PRINT):** Date of application: ______________________

Last Name: ______________________ First Name: ______________ Middle Initial: ________

Social Security: ______________________ DOB: ________________ Sex: ___________

Phone #: ______________________ UCI/MACSIS # (If applicable): ________________

Emergency Contact Name: ____________________ Emergency Contact #: ________________

Address (*if homeless, provide shelter address*): ______________________________

City, State, ZIP: ______________________________

Race: ☐ American Indian or Alaskan Native ☐ Caucasian/White ☐ American Indian/Alaskan-Native & Black/African American ☐ African American/Black ☐ Asian ☐ African American & Caucasian ☐ Asian & Caucasian ☐ Other Multi-Racial ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian/Alaskan Native & Caucasian

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic or Non-Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Legal Separation

Veteran? ☐ Yes ☐ No

Forensic History:

Is the applicant applying for a Reentry Program? (i.e., Returning Home Ohio, HAP/PATH) ☐ Yes* ☐ No

*If yes, please attach one of the following: Proof of most recent incarceration, PSI, and/or ODRC referral.

Is any member of the household subject to a lifetime state sex offender registration program in any state? ☐ Yes* ☐ No

*If yes, who? ______________________ What State? ______________

Application Processor: This information must be checked and verified @ www.nsopw.gov and www.sheriff.cuyahogacounty.us/offendersearch.asp

Referring Agency: ______________________________

Case Manager: ______________________ Phone # ________________

Fax# ________________ E-mail Address: ______________________

Household Members – list all additional household members (PLEASE PRINT)

Last Name | First Name | Middle Initial | Relationship to Head of Household

☐ Male ☐ Female ☐ Yes ☐ No

Social Security # | Date of Birth | Race | Sex (M/F) | Disabled? (Y/N)

Last Name | First Name | Middle Initial | Relationship to Head of Household

☐ Male ☐ Female ☐ Yes ☐ No

Social Security # | Date of Birth | Race | Sex (M/F) | Disabled? (Y/N)

Last Name | First Name | Middle Initial | Relationship to Head of Household

☐ Male ☐ Female ☐ Yes ☐ No

Social Security # | Date of Birth | Race | Sex (M/F) | Disabled? (Y/N)

Last Name | First Name | Middle Initial | Relationship to Head of Household

☐ Male ☐ Female ☐ Yes ☐ No

Social Security # | Date of Birth | Race | Sex (M/F) | Disabled? (Y/N)

Last Name | First Name | Middle Initial | Relationship to Head of Household

☐ Male ☐ Female ☐ Yes ☐ No

Social Security # | Date of Birth | Race | Sex (M/F) | Disabled? (Y/N)

Medical Expenses:

The medical expense deduction is permitted **ONLY** for households in which the *Head of Household or Spouse* is at least 62 years of age, or for a person with disabilities. ***Please answer the questions and provide proof of any/all expenses:***

Do you pay for any out-of-pocket medical expenses on a regular basis (i.e., prescription medication)?

☐ **Yes*** ☐ **No** *If Yes, please attach proof of all expenditures

Childcare Expenses: Does the Head of Household pay for childcare while any adult household members are working, searching for employment or attending school?

☐ **Yes*** ☐ **No** *If Yes, please attach proof of expense

Banking Information: Does anyone in the household currently have a Checking or Savings Acct?

☐ **Yes*** ☐ **No** *If Yes, please attach proof of all accounts

SOURCE/AMOUNT OF MONTHLY INCOME	HEAD OF HOUSEHOLD	SPOUSE	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER	HOUSEHOLD MEMBER
Employment						
Unemployment						
Social Security						
TANF						
Alimony						
Child Support						
Pension/Annuities/IRA						
Veterans Benefits						
Interest/Dividend						
Contributions or Gifts						
Income from Assets						
Worker's Comp						
No Income (Must include Notarized Statement of No Income)						

Homeless Verification *(Please attach documentation of homelessness with application)***:**

Are you currently homeless? ☐ Yes ☐ No* **If No, please proceed to the signature section*

Are you currently staying in an emergency shelter? ☐ Yes ☐ No

Are you staying in transitional housing after coming from a shelter? ☐ Yes ☐ No

Are you staying in places not meant for human habitation? (i.e., street, park, car) ☐ Yes ☐ No

Have you been continuously homeless (staying in shelter/on streets) for one year or more? ☐ Yes ☐ No

Have you had at least 4 episodes of homelessness (staying in shelter/on streets) in the past 3 yrs? ☐ Yes ☐ No

I certify that of the information on this application is true and complete to the best of my knowledge.

______________________________ ________________

Applicant’s Signature Date

______________________________ ________________

Case Manager’s Signature Date

______________________________ ________________

Case Manager’s Supervisor’s Signature Date

"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 and any owner (or any employee of HUD 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 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 **208 (a) (6), (7) and (8).** Violation of these provisions are cited as violations of 42 U.S.C. Section **408 (a) (6), (7) and (8).**

Release of Information

This release of information form is used specifically for participants in an EDEN rental subsidy program. Persons who qualify for the program are eligible to receive housing subsidy and supportive services for the duration of their participation in the program.

Program Name: ____

Soc Sec #: ______________________________________DOB: ________________________

I, ____ (print participant's name)

give permission to EDEN and _____________________________ (supportive service agency), and

____ (designated board – if applicable)

to release information to each other for the purpose of assisting me in maintaining a housing subsidy. Information is needed to determine eligibility, subsidy needed, appropriate service plan, participant benefits and outcomes, grant matching requirements, and administrative accountability through information regarding disability, demographics, income, household composition, and services provided.

This release will remain in effect for the **entire length of time I am a participant in the rental subsidy program and linked with the above agency.**

____________________________________ __________________
Signature of Participant Date

____________________________________ __________________
Signature of Case Manager Date

A Housing Resource and Development Agency
7812 Madison Avenue, Cleveland, OH 44102 (216) 961-9690 FAX (216) 651-4066
Shelter Plus Care FAX (216) 651-6692 www.edeninc.org info@edeninc.org

Disability Verification Form

Date of Verification: ______________________________

Last Name: _____________________________________ First Name: ________________________ Middle Initial: ___

Referring Agency: _______________________________________ Case Manager: _______________________________

Type of Disability:

- ☐ Serious Mental Illness
- ☐ Chronic Substance Abuse
- ☐ Co-Occurring / Dual Diagnosis
- ☐ AIDS and Related Diseases
- ☐ Other (Please Specify): ____

The following information must be completed and signed by an independently licensed health professional (e.g., Psychiatrist, Psychologist, Nurse, Counselor, or Social Worker) or a M.D. certifying disability eligibility.

Disability Eligibility – Qualifying Diagnosis(es) from DSM IV – TR (Diagnosis and Code is Required)

Code: ______________________ Diagnosis: ____

Code: ______________________ Diagnosis: ____

Disability Status

- ☐ Yes (Currently Receiving SSI/SSDI)
- ☐ No

____ ____________________________

Signature/License No. Date

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