OFFICE USE ONLY

Date /Time stamp here

4055 Executive Park Drive, Suite 240
Cincinnati, OH 45241

Phone (513) 554 4567
Fax (513)554-0514
TTY (800) 927-9275

referral@newhousingohio.org

Housing Application/Project-based Section 8

Applicant Name:_____ Date:_____
Address:_____ City/Zip:_____
Phone:_____ DOB:_____ SSN:_____
Please list all states in which you have ever resided:
_____

Co-Applicant/Other Adult:_____
Address:_____ City/Zip:_____
Phone:_____ DOB:_____ SSN:_____
Please list all states in which you have ever resided:
_____

1. Current Living Arrangements (Please check one):
   - ___ State Hospital
   - ___ Living w/family
   - ___ Correctional Facility
   - ___ Own Apartment (unaffordable)
   - ___ Temporary Shelter/Homeless
   - ___ Transitional Housing Program
   - ___ Group Home
   - ___ Other (explain)

   Explanation:_____

2. Basic Information:
   - Marital Status ___ Married ___ Single _____ Divorced/Widowed
   - Gender ___ Female ___ Male _____ Prefer not to answer
   - Number of persons who will be living in the unit? _____
   - Age (s) _____ Are you 62 or 60 years and older with a disability? _____
   - Do you need reasonable accommodation due to a disability? Yes ____ No ____
   - Race: ____ White ____ Black ____ Asian ____ Pacific Islander ___ Alaskan Native _____American Indian _____ Other _____ Prefer not to answer
   - Ethnicity: ___ Hispanic ___ Non-Hispanic _____ Prefer not to answer
   - Are you a veteran? Yes____ No _____

3. Employment Status:
   _____ Full Time _____ Part Time _____ Self Employed _____ Unemployed

4. Number of bedrooms required by applicant:
   ___ 1 BR ___ 2BR ___ 3BR ___4 BR

If applicable, please list the names and requested information for all household members not named on page 1 of the application:

Name:	Birthdate/ SS#:	States Resided:
Name:	Birthdate/ SS#:	States Resided:
Name:	Birthdate/ SS#:	States Resided:

5. Do you have a preference is to the county you would prefer to live: ___Warren County **(WC)**
   ___Clinton County **(CC)** ___Butler County **(BC)** ___ Preble County **(PC)**

6. Type of program/property applicant is requesting:
   - ___ Herkin's House (Adult Group Home) (WC)
   - ___ Smith House (CC)
   - ___ Barker House (CC)
   - ___ Broadway (WC)
   - ___ Cambridge (WC)
   - ___Connie's
   - ___Crossing (WC)
   - ___Doan (CC)
   - ___ Grove (CC)
   - ___Fairwinds
   - ___ Harrison (WC)
   - ___Main (WC)
   - ___Mound (WC)
   - ___ Randy's Place (WC)
   - ___ Riverdale (WC)
   - ___Park (WC)
   - ___ Forest (WC)
   - ___ Esther-Tuke (CC)
   - ___ William-Tuke (WC & CC)
   - __ Brookwood (BC)
   - ___Doty's House (BC)
   - ___ Jackson Lane Group Home (BC)
   - ___ Happy Valley Group Home (BC)
   - ___ Jackson Lane Apts (BC)
   - ___Curtis St Apts and Efficiencies (BC)
   - ___Aaron (BC)
   - ___ Bonita (BC)
   - ___ Farm (Men's Recovery) (CC)
   - ___ Blanchester (Women's Recovery) (CC)
   - ___ Prestwick Apts (PC)

7. Are you currently living in subsidized housing? _____Yes _____No
   If yes, what type of assistance are you receiving? _____ Voucher _____Project-based

8. Have you ever lived in NHO housing before? _____Yes _____No
   If yes, did you leave in good-standing? _____Yes _____No, if not please explain:
   _____

9. Have you or any member of your household ever been evicted in the past? ____Yes _____No
   If yes, please explain: _____

10. Do you or any member of your household have a history of violence that could affect the safety of other tenants, NHO staff, and/or other professionals? ____Yes _____No

11. Is there a history of destruction of property/assault? _____Yes _____No
    If yes, are you invoking VAWA protections? _____

12. Are you or any member of your household subject to State/Nationwide lifetime sex offender registration? _____Yes _____ No

13. Are you or any adult household member currently a student? _____Yes _____No

14. Describe any additional information about your past rental history that you think would be helpful: _____
    _____

15. Do you have specific daily living skills where you will need assistance?
    _____ Budgeting/Shopping _____ Neighbor Relations _____ Cleaning _____ Cooking
    _____ Respect for Property _____ Setting up Apartment ____Live-in Aide

16. Current **Monthly Income**: (list all sources of income such as SSI, SSDI, wages, unemployment, retirement, disability assistance, child support, etc.):
    Name: _____ Source: _____ Monthly amount $ _____
    Name: _____ Source: _____ Monthly amount $ _____

17. Current **Assets:** (list all sources of assets such as Direct Express card, Checking, Savings, Other banking etc.):
    Asset Type: _____ Financial Institute: _____ Current Value $ _____
    Asset Type: _____ Financial Institute: _____ Current Value $ _____
    Asset Type: _____ Financial Institute: _____ Current Value $ _____

18. Emergency Contact:
    Name: _____ Relationship: _____
    Address: _____ Phone: _____

19. Personal/Agency Reference:

Name:_____ Relationship:_____
Address:_____ Phone:_____

Agency Referral/Name of Organization:_____

Case Managers Name: _____ **Phone:** _____

Email Address:_____

Your signature on this application gives New Housing Ohio, Inc. written consent to verify information in this application. A false statement or misrepresentation of your application will effect approval of residency.

Date:_____ **Date:**_____

_____ _____

Applicant Signature **Co-Applicant/Other Adult Signature**

New Housing Ohio, Inc. does not discriminate in its housing policies with respect to an applicant's race, creed, color, age, gender, family composition or disability.

Agency Referrals will only be accepted via email to referral@newhousingohio.org
All other applications may be brought or mailed to the NHO corporate office located at 4055 Executive Park Dr., Suite 240, Cincinnati, OH 45241

NHO RESERVES THE RIGHT TO REFUSE SERVICES

Office Use Only

___ AOD Assessment, Treatment Plan, 508 Eligibility
___ Proof of Section 8 Application (if open)
___ Proof of Citizenship/Social Security Card
___ Proof of Birth/ Birth Certificate
___ State-issued Photo ID
___ Verification of Income

___ Verification of Assets

___ Release of Information

- ___ Emergency Contact (HUD form 92006)
- ___ Mental Health/AoD Provider
- ___ Local Housing Authority
- ___ Other _____
- ___ Other _____
- ___ Other _____
- ___ Other _____

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:

Mailing Address:

Telephone No: **Cell Phone No:**

Name of Additional Contact Person or Organization:

Address:

Telephone No: **Cell Phone No:**

E-Mail Address (if applicable):

Relationship to Applicant:

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ Check this box if you choose not to provide the contact information.

Signature of Applicant **Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.

VERIFICATION OF CHRONICALLY MENTALLY ILL

DATE:

TO: _____

_____

_____

FROM: _____

_____

_____

SUBJECT: Verification of Information Supplied by an Applicant for Housing Assistant

NAME: _____

SOCIAL SECURITY #: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to assure timely processing of the application for assistance. Enclosed is a self-addressed, stamped envelope for this purpose, this applicant/tenant has consented to this release of information as shown below.

TO THE HOUSEHOLD MEMBER:
YOU DO NOT HAVE TO SIGN THIS FORM IF EITHER THE REQUESTING ORGANIZATION OR THE ORGANIZATION SUPPLYING THE INFORMATION IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances, which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

_____ _____

HOUSEHOLD MEMBER'S SIGNATURE 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 disclosure 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 the 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). Violation of these provisions are cited as violations of 42 U.S.C. 408(f), (g) and (h).

VERIFICATION FOR CRONICALLY MENTALLY ILL

APPLICANT'S NAME:_____

In you professional opinion, does the above listed person meet the definition listed below as Chronically Mentally Ill?

YES_____ **NO**_____

DEFINITION:

An adult who has a chronic mental illness, i.e., if he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently (e.g., by limiting functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc.), and whose impairment could be improved by more suitable housing conditions.

NOTE: A person whose sole impairment is alcoholism or drug addiction will not be considered to be handicapped for the purposes of the Section 202 program.

_____ _____

SIGNATURE OF PERSON COMPLETING FORM **DATE**

_____

TITLE OF PERSON COMPLETING FORM

SAVE: CMI-DIS

Verification of Disability

The person signing below verifies that the following individual _____ has a disability or special need as checked below.

We are releasing this information with the approval of the above individual for the purpose of helping him or her acquire housing.

Check all that apply

_____ Severe Mental Illness
_____ Substance Addiction
_____ HIV/AIDS
_____ Co-occuring / Dual Diagnosis
_____ Other (Specify)

_____ Physical Disability
_____ Victim of Domestic Violence
_____ Developmental Disability
_____ Physical / Emotional Abuse

We attest that our agency and the individual signing below are qualified to make this determinitation.

_____
(Agency)

_____ _____
(Individual completing form) (Date)

_____
(Position with agency)

_____
(Professional qualifications/designations such as MSW, Psychologist, Qualified Mental Health Professional, Qualified Substance Abuse Professional, MD, etc.)

By signing below, I authorize the release of this information.

_____ _____
(Applicant/Tenant) (Date)

_____ _____
(Applicant/Tenant) (Date)

Verification of Homeless Household Status

PROJECT NAME: _____

APPLICANT NAME: _____

ADDRESS: _____ UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

Please check as appropriate:

☐ 1. I reside in temporary accommodations and am "doubled-up," meaning that more than two households reside in one housing unit. For example, an adult with 2 children temporarily residing with friends or family members qualifies as "doubled-up."

☐ 2. I reside in an overcrowded housing unit meaning that there are more than two persons per sleeping area (including the living room as a sleeping area) in the housing unit. For example, seven people residing in a two-bedroom apartment qualifies as overcrowded housing.

☐ 3. I have received an eviction, foreclosure, or condemnation notice. (Attach notice.)

☐ 4. I have a primary nighttime residence that is one of the following:

☐ A. Supervised temporary shelter including transitional housing for the mentally ill.

Name of shelter/housing _____.

☐ B. An institution that provides temporary residence for individuals intended to be institutionalized. Name of institution _____.

☐ C. A public or private place not designed for or ordinarily used as regular sleeping accommodation for human beings. For example, living on the street or in a park.

☐ D. A "mobile home" that was constructed before 1976 and does not meet the National Manufactured Hosing Construction Safety Standards. (Attach picture or construct date document.)

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understands that providing false representations herein may constitute an act of fraud.

_____ _____

Applicant Signature Date

_____ _____

Case Manager/Project Representative Date

4055 Executive Park Dr. Suite 240
Cincinnati, OH 45241

Phone • (513) 554-4567
Fax • (513) 554-0514

ZERO INCOME STATEMENT

I have stated during this verification process that I have no income at this time. I have not received income since _____. I do not expect to receive any income until _____.

Explanation of how basic living expenses are met:

_____

_____

_____

I am assisted with the following:

___ Food

___ Shelter

___ Other (specify) _____

I certify that the statements made by me are true to the best of my knowledge. I understand that providing false information can be considered fraud, which is a punishable act under the law. I will notify the person completing this form immediately if my financial situation changes.

Client Name _____

Client Signature _____ Date _____

NHO Staff Signature _____ Date _____

Date received at NHO office: _____

Received by: _____

Zero Income Statement 12/2010

n h o
building communities
4055 Executive Park Drive, Suite 240
Cincinnati, OH 45241
Phone • (513) 554-4567
Fax • (513)554-0514

APPLICANT / TENANT STATEMENT

I/We certify that the information given to New Housing Ohio on household composition, income, net family assets, allowances, and deductions is accurate and complete to the best of my/our knowledge and belief. I/We understand that false statements or information are punishable under Federal, State, and Local law. I/We also understand that false statements or information are grounds for termination of housing assistance and termination of tenancy.

Signature of Head of Household _____ Date _____

Signature of Spouse or Co-Head _____ Date _____

If you believe you have been discriminated against, you may, call the Fair Housing and Equal Opportunity National Hotline toll-free at 1-800-424-8590.

*After verification by New Housing Ohio, the information will be submitted to the Department of Housing & Urban Development on Form HUD-50059. See the Federal Privacy Act for more information about its use.

ASSETS DISPOSED OF FOR LESS THAN FAIR MARKET

CERTIFICATION: Please check off the applicable box indicating whether you have or have not disposed of assets for less than fair market value within the past two years. Disposing of an asset means that you have given that asset away, sold it, or otherwise transferred ownership of it to others. When making this determination, exclude any assets transferred as a result of bankruptcy, foreclosure, divorce, or separation. Also, exclude assets received from judgements or settlements that you placed in a nontevocable trust.

_____ I do hereby certify that **I HAVE NOT** disposed of any assets for less than Fair Market Value within the past two years.

_____ I do hereby certify that **I HAVE** disposed of assets for less than Fair Market Value within the last two years.

INSTRUCTIONS: If you checked the first line, above, please sign this form. If you checked the second line, above, please complete the following chart, and then sign the form.

When completing the chart, use a separate column for information about each asset disposed of in the last two years. Note that the expenses that would be necessary to sell an asset or convert it to cash (item #4 may include, for example, broker's fees, attorney's fees, and settlement costs. Also note the amounts in item #7, below, will be counted in your assets only if those amounts together are more than $1,000.

I understand that I must provide to the site office and attach to this form documents to confirm each asset's fair market value, the amount of the expenses that would be necessary to sell the asset or convert it to cash, and the amount received for the asset.

	ASSET	ASSET	ASSET
1. Description of asset			
2. Date disposed of			
3. Fair Market Value as of date of disposal			
4. Expenses necessary to sell or convert asset			
5. Asset's cash value (#3 minus #4)			
6. Amount received (if any) for asset			
7. Includable amount (#5 minus #6)			

Signature of Head of Household _____ Date _____

Signature of Spouse/Co-Head _____ Date _____

Signature of Witness _____ Date _____

WARNING: SECTION 1001 OF TITLE 18 OF THE UNITED STATES CODE MAKES IT A CRIMINAL OFFENSE TO MAKE A WILLFULLY FALSE STATEMENT OR MISREPRESENTATION TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES AS TO ANY MATTER WITHIN ITS JURISDICTION.

building communities
4055 Executive Park Dr. Suite 240
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Phone • (513) 554-4567
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Authorization for Release of Information

I, _____ hereby authorize exchange of information between
New Housing Ohio, Inc. and

_____
Name of party releasing information

_____
Agency Name

_____
Address

_____ _____
City, State, Zip Phone

_____ _____ _____
Full Name of Client Date of Birth Social Security Number

Information to be exchanged includes release of information concerning HIV testing or treatment of AIDS<AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions.

The information specifically included in this authorization is:

_____ Admission or Discharge Summary
_____ Social/Family History
_____ Physical Examination
_____ School or Job History
_____ Other _____
_____ Psychological/Psychiatric Assessment
_____ Current/Past Medications
_____ Laboratory Findings
_____ Treatment Plan

Purpose or need of disclosure _____

A photocopy of this form is considered to be an equivalent of this form.
This information is being disclosed from record the confidentiality of which may be protected by Federal Law.
REDISCLOSURE OF THIS INFORMATION IS STRICTLY PROHIBITED.
I UNDERSTAND THAT THIS CONSENT TO DISCLOSE may be revoked by me at any time by written notice except to the extent that action has been taken thereon. This consent will expire in two years (24 months) after the date below or sooner at my discretion in which case the authorization will expire on _____.

I acknowledge that I have read and fully understand this authorization.

_____ _____
DATE Signature of client or other legally authorized party

_____ _____
Signature of witness Relationship to client

Any information about drug and alcohol abuse has been disclosed to you from records protected by Federal Law. Federal regulations prohibit you from making further disclosure without written consent of the person to whom it pertains or is otherwise permitted by such regulation. A general authorization for release of medical or information is insufficient for this purpose.