CSP#_____

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.

❑ Release of Information (ROI)

❑ Demographics Form

❑ Eligibility and Prioritization Form

❑ Length of Stay (LOS Calculator) Print Out

❑ Documentation of Homelessness (CSP Printout and/or Street Homeless Verification Form)

❑ Certification of Disability (COD or SSI/SSDI Award Letter)

❑ Vulnerability Assessment

❑ 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 SSA.
- ❑ Original birth certificate or letter/form requesting 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

❑ Unit Specific Documentation for Veteran's and Family Units (If applicable)

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 disability 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.

	Printed Name	Signature	Date
Provider Agency Rep.			
Mental Health Provider			

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 housing providers: Amethyst, AIDS Resource Center of Ohio (ARCO), Columbus Area Integrated Health Services (CAIHS) Community Housing Network (CHN), Maryhaven, National Church Residences (NCR), Southeast, Inc., Volunteers of America of Greater Ohio (VOAGO), YMCA, 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, 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.

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
1.			
2.			
3.			
4.			
5.			

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: 111 Liberty St., Suite 150, Columbus, OH 43215. 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.

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 Columbus ServicePoint (CSP), 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.

IX. **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.

_____ _____

Signature, Head of Household **Date**

For USHS Use Only

Rcvd By_____ Date of Revocation: _____

CSP#_____

❑ Homeless ❑ ADAMH ☐ Veteran ☐ Medical

Unified Supportive Housing System (USHS) Prospective Applicant Demographics			
Last Name	First Name	Middle Initial	Suffix
Alias/Maiden Name			
Date of Birth			
Social Security Number			
Phone Number			
Navigator/Outreach Provider Name (if applicable):			

Navigator Navigator/Outreach Provider Email	Navigator/Outreach Provider Phone

Race (Voluntary-Please Select One or More):

❑ White	❑ American Indian/Alaskan Native	❑ Multi-Racial
❑ Black/African American		❑ Other
❑ Asian	❑ Native Hawaiian/Other Pacific Islander	

Ethnicity (Voluntary):

❑ Hispanic/Latino	❑ Non-Hispanic/Latino

Are you a US citizen or Legal US Resident?

❑ Yes ❑ No

Marital Status:

❑ Single	❑ Married	❑Other _____
❑ Divorced	❑Separated	❑ Domestic Partnership/Common-Law

Gender:		
❑ Male ❑ Female	❑ Transgendered Female to Male ❑ Transgendered Male to Female	❑ Other _____

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

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 ❑ Handicap Accessible Parking	❑ Hearing disability ❑ Grab bars and Handrails ❑ Modification for vision or hearing impairment
Total Monthly Income:	$	

Do you receive any of the following income: (check all that apply)		
❑ SSI ❑ SSDI ❑ Disability Assistance ❑ Pension/Veteran's Administration (Military Pay)	❑ Self-Employment ❑ Unemployment Benefits ❑ Workers Compensation ❑ Alimony ❑ Educational Financial Assistance (Financial Aid)	❑ TANF/AFDC (Public/General Assistance) ❑ Court-Ordered Child Support ❑ Informal Child Support ❑ Wages from job

Do you have any of the following? (check all that apply)	
❑ Checking Account ❑ Savings Account ❑ Life Insurance	❑ Retirement ❑ Direct Express Account

Prospective Applicant Enrolled In: (check all that apply)		
❑ Medicaid	❑ Medicare	❑ Ohio SCHIP (CareSource, Molina, etc.)
Do you have 1 or more Pets?	If yes, what type of animal is it?	Is your pet a service or therapeutic 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 Manger Name (If Applicable)		
Have you ever Served in the US Military?	If yes, what was the character of your discharge?	
❑ Yes ❑ No	❑ Honorable ❑ Other than Honorable ❑ General ❑ Refused	❑ Medical ❑ Bad Conduct ❑ Dishonorable
Are you Eligible for Veteran Services?		
❑ Yes ❑ No ❑Unknown	❑Refused	
Prospective Applicant's Current Living Arrangement		
❑ Living in a place unintended for habitation (street, car, under bridge, in camp/on the land etc.) ❑ Domestic Violence Situation ❑ Living with Friends or Relatives	❑ Emergency Shelter ❑ Psychiatric Hospital ❑ Hospital Medical Unit ❑ Rental Housing ❑ Transitional Housing ❑ Residential Care Facility	❑ Substance Abuse Treatment Facility ❑ Doubled-up ❑ Other_____
Will There be Another Adult Residing with you in the Household?	❑ Yes* ❑ No	***If yes, Please Give that Person's Name Below:** _____
Do currently have or plan to have Legal Custody of any Minor Children not currently residing with you?		
❑ Yes* ❑ No	*If so, please ensure that minor children are on the Release of Information Form.	

***Please Note:** All prospective applicants are given two (2) opportunities to accept a housing unit that is not substandard housing for any reason. 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.

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 File 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 verify, under perjury of law, that the above information provided by me on this form is true to the best of my knowledge.

_____ _____

Signature, Prospective Applicant

Provider Agency Use Only

This client meets the definition of "persons with disabilities" because they reside in a household composed of one or more persons, where the Head of the Household has the following disability:

(Check All That Apply)

Serious Mental Illness
❑ Yes ❑ No

Substance Use Disorder
❑ Yes ❑ No

Long Term (Chronic) Health Disorder
❑ Yes ❑ No

Developmental Disability
❑ Yes ❑ No

Signature, Provider Agency Representative

Date

Printed Name

Provider Agency Name

Unified Supportive Housing System (USHS) Eligibility & Prioritization Form	
Client Name:	
***Note: If your client is a Non-Veteran in Transitional Housing, they are automatically Eligibility A.**	
1. Using the LOS Calculator, please list the total amount of days Prospective Applicant has experienced homelessness:	
2. Based on CSP and/or Verification of Street Homelessness, has the Prospective Applicant been homeless for a total of at least 120 days?	❑ Yes ❑ No
(If yes skip to Question #4)	
3. Based on CSP and/or Verification of Street Homeless has the Prospective Applicant had at least 4 separate occasions of homelessness, where the combined total is at least 120 days and each break in homelessness included at least 7 consecutive nights?	❑ Yes ❑ No
STOP If you answered No to both Questions #2 and #3 please see Option A	
4. Based on CSP and/or Verification of Street Homelessness has the Prospective Applicant been homeless at least 12 **cumulative** months?	❑ Yes ❑ No
5. Based on CSP and/or Verification of Street Homelessness has the Prospective Applicant been homeless for at least 12 **consecutive** months?	❑ Yes ❑ No
6. Based on CSP and/or Verification of Street Homelessness has the Prospective Applicant had 4 separate verifiable occasions of homelessness within the past 3 years , where the **combined** total is at least 12 months and each break in homelessness included at least 7 consecutive nights?	❑ Yes ❑ No
(If Yes to 5 or 6, see option D)	

If No to Questions #4-6, please see Option B.
If you answered No to #5 and #6, but Yes to #4, see Option C.

Preliminary Eligibility	
A. Homeless Eligibility	Your Prospective Applicant is eligible for USHS, but will be given the lowest prioritization due to current housing status. Utilization of alternative housing options is suggested.
B. Rebuilding Lives Homeless Eligibility	Your Prospective Applicant is eligible for USHS; Please continue to consider non-USHS housing options and opportunities with your Prospective Applicant.
C. Rebuilding Lives Homeless Priority	Your Prospective Applicant is eligible for USHS and will be given priority over other Rebuilding Lives individuals in the pool. Upon referral please consider all available housing options to ensure your Prospective Applicant is housed as quickly as possible.
D. HUD Chronically Homeless Priority	Your Prospective Applicant is eligible for USHS and will be given priority over non-HUD chronic individuals in the pool. Upon referral please consider all available housing options to ensure your Prospective Applicant is housed as quickly as possible.

Has the Prospective Applicant resided in an institution (hospital, jail or other) for less than 90 days during his/her homelessness?

❑ Yes* ■ No

*If yes, please submit written verification from the institution stating that the Prospective Applicant has been residing their less than 90 days, in addition to LOC, CSP Printout and/or Verification of Street Homeless Form. The document must be signed, dated and on institution letterhead.

Provider Agency Signature _____ Date _____

USHS Program Manager Signature _____ Date _____

This Page is Intentionally Blank
Please include: Length of Stay (LOS) Print-Out

This Page is Intentionally Blank
Please include: Columbus ServicePoint Entry/Exit Print-Out

This Page is Intentionally Blank
Please include: Verification of Street Homelessness Form and/or documentation of institutional stay of less than 91 days, if applicable.

Certification of Disability

"Persons with Disabilities" is a family composed of one or more persons, where the Head of Household has a disability.

1. A person shall be considered to have a disability if such person has a physical, mental, or emotional impairment 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 (h) 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.

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 hereby certify that _____ is disabled.

I further certify that I am authorized to make this determination.

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

Authorized Signature Date

Printed Name

CSP#_____

Unified Supportive Housing System (USHS)
Vulnerability Assessment

Consent for Interview

I am here to discuss your housing, health and service needs. With your permission, I will ask you some questions that will give me an idea of the best way to serve you. It should only take about 10 minutes of your time. Only authorized agencies will be able to assess and review your information and this will be for the sole purpose of securing a stable, decent and safe housing option. If at any time, you feel uncomfortable or upset during the course of the interview, you may ask me to take a break, stop or to skip a question. All of your personal and identifying information will be kept secure and individuals who utilize it will not share your information. Do you have any questions at this time?

PLEASE SIGN BELOW YOUR INFORMED CONSENT TO BE INTERVIEWED AND SCREENED FOR A PERMANENT SUPPORTIVE HOUSING OPTION

Your signature (or mark) below indicates that you have read (or been read) the information provided above and have gotten answers to your questions.

_____ _____
Signature or Mark of Prospective Applicant Date

_____
Printed name of Prospective Applicant

_____ _____
Interviewer's Printed Name Date

_____ _____
Location Time

Unified Supportive Housing System (USHS) Vulnerability Assessment		
1. In what language do you feel best able to express yourself?		
❑ English ❑ Spanish ❑ Mandarin ❑ French ❑ Other_____		
2. First Name	3. Last Name	
4. Nickname	5. Date of Birth	
6. How old are you?	7. Last Four Numbers of Your SSN:	
8. In the past three years, how many times have you been homeless and then housed again?	❑0 (N/A) ❑1 ❑2 ❑3+	❑ Refused
9. In the past year, how many times have you been hospitalized as an in-patient?	❑0 (N/A) ❑1 ❑2 ❑3+	❑ Refused
10. In the past year, how many of your encounters with police resulted in a jail or prison stay?	❑0 (N/A) ❑1 ❑2 ❑3+	❑ Refused
11. Where do you sleep most frequently?	❑ Shelters ❑ Outside (Camp/Streets) ❑ Car/Van/RV ❑ Jail/Prison ❑ Treatment Facility/Hospital ❑ Residential Care Facility	❑ Abandoned Home ❑ With Friends or Family ❑ Transitional Housing ❑ Your own home or apartment ❑ Other

Physical Health			
12. Where do you usually go for healthcare or when you're not feeling well?	❑ Private Physician/Clinic ❑ Mt Carmel ❑ Healthcare for the Homeless ❑ Columbus Health Center Clinic	❑ OSU Hospitals ❑ Southeast ❑ North Central ❑ Grant Hospital/Ohio Health	❑ VA ❑ Free Clinic ❑ Other ER/Hospital ❑ Does not go for care ❑ Other (specify)
Do you have any of the following medical conditions?			
13. Kidney disease/ End Stage Renal Disease or Dialysis	❑ Yes ❑ No ❑ Refused		
14. History of Frostbite, Hypothermia, or Immersion Foot	❑ Yes ❑ No ❑ Refused		
15. Liver Disease, Cirrhosis, Hepatitis C or End-Stage Liver Disease	❑ Yes ❑ No ❑ Refused		
16. HIV+/AIDS	❑ Yes ❑ No ❑ Refused		
17. Pregnant	❑ Yes ❑ No ❑ N/A ❑ Refused		
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?			
18. History of Heat Stroke/Exhaustion	❑ Yes ❑ No ❑ Refused		
19. Heart Disease, Arrhythmia, Stroke, High Blood Pressure or Irregular Heartbeat	❑ Yes ❑ No ❑ Refused		
20. Diabetes	❑ Yes ❑ No ❑ Refused		
21. Cancer	❑ Yes ❑ No ❑ Refused		
22. Emphysema, Chronic Bronchitis, COPD, Asthma, or Tuberculosis.	❑ Yes ❑ No ❑ Refused		
23. Is Medical Condition Under Treatment?	❑ Yes ❑ No ❑ Refused		
OBSERVATION ONLY 24. Interviewer, do you observe signs or symptoms of serious health conditions?	❑ Yes ❑ No		

Substance Abuse	
25. Have you ever had problematic drug or alcohol use, abused drugs or alcohol or been told that you do?	❑ Yes ❑ No ❑ Refused
26. Have you consumed alcohol almost every day for the past month?	❑ Yes ❑ No ❑ Refused
27. Have you ever used injection drugs or shots?	❑ Yes ❑ No ❑ Refused
28. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	❑ Yes ❑ No ❑ Refused
OBSERVATION ONLY 29. Interviewer, do you observe signs or symptoms of problematic alcohol or drug abuse? (Deterioration in functioning, cognitive damage, lack of self-care or active use.)	❑ Yes ❑ No
Mental Health	
30. Have you been ever told that you were diagnosed with a mental health issue?	❑ Yes ❑ No ❑ Refused
31. Are you currently or have you ever received treatment for mental health reasons?	❑ Yes ❑ No ❑ Refused
32. Have you had a serious brain injury or head trauma that required hospitalization or surgery?	❑ Yes ❑ No ❑ Refused
33. Have you been ever told that you were diagnosed with a learning or developmental disability?	❑ Yes ❑ No ❑ Refused
OBSERVATION ONLY 34. Interviewer, do you observe signs of confusion, evidence of developmental disability, dementia, or memory impairment? (Self-talk, distracted, paranoia, fear, phobic, depressed or manic)	❑ Yes ❑ No

Significant Challenges and Functional or Social Impairments			
35. As a minor were you ever in foster care or abused or neglected by caregivers?		❑ Yes ❑ No ❑ Refused	
36. Have you ever left home because of domestic violence?		❑ Yes ❑ No ❑ Refused	
OBSERVATION ONLY 37. Interviewer, do you observe signs of problematic social behavior? (Responds in angry, profane, obscene or menacing verbal ways, intimidating, impaired ability to deal with stress, no apparent social network, difficulty engaging positively with others)		❑ Yes ❑ No	
37. Do you have a permanent physical disability that limits your mobility? (i.e., wheelchair, amputation, unable to climb stairs)		❑ Yes ❑ No ❑ Refused	
38. Have you been the victim of a violent attack since you've become homeless?		❑ Yes ❑ No ❑ Refused	
39. Do you have any friends, family, or other people in your life you can count on?		❑ Yes ❑ No ❑ Refused	
OBSERVATION ONLY 40. Interviewer, do you observe signs of Prospective Applicant not being able to meet basic needs? (Poor hygiene/ clothing, unable to access food on own or no insight on needs)		❑ Yes ❑ No	
41. Do you have enough money to meet all of your expenses on a monthly basis?		❑ Yes ❑ No ❑ Refused	
42. How do you make money?	❑ Work (earned income) ❑ Work (under the table) ❑ Plasma Center ❑ Pension/ Retirement	❑ SSI ❑ VA ❑ SSDI/SSA ❑ Unemployment Check ❑ General Assistance	❑ No Income ❑ Panhandling ❑ Sex Work/Trade ❑ Drug Trade ❑ Recycling/ Scrapping

Office Use Only

Vulnerability Assessment Score

Authorized Signature

Date

Printed Name/Provider Agency Name/Title

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 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/AFDC (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 is Intentionally Blank
Please include: Income Documentation if Client did not complete the Zero Income Statement

Verification of Identity and Citizenship

Please include the following for each household member:
1. Social Security Card or SSN printout
2. United States (US) Birth Certificate or copy of request for US Birth Certificate; US passport is also acceptable.
3. Current State of Ohio issued photo id or Driver's License with Franklin County address (Not required for minors)

*Please verify that all names match across documentation, if not please provide documentation of legal name change.

Unit Specific Documentation:

For a **Family Unit** (families with minor children) please provide a copy of the ODJFS Benefits Printout.

For a **Veteran Unit** (for VA benefits eligible applicant) please provide documentation of Veteran's Benefits.