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**NEW HOME DEVELOPMENT COMPANY, INC.**  
 617 N. Walnut St. #12, Bryan, OH 43506 PH: 419-519-3075

Date: \_\_\_\_\_

**HOUSING APPLICATION**

Applicant's Name: _____		Male/Female	
Street Address: _____	City: _____	State: _____	Zip Code: _____
Social Security #: _____	Date of Birth: _____	Telephone #: _____	
Case Manager: _____		Marital Status: _____	

REASON APPLYING FOR HOUSING ASSISTANCE: \_\_\_\_\_

HOUSING PREFERENCE:    SHARED                      SINGLE                      FAMILY

CURRENT HOUSING:       STANDARD                      SUB-STANDARD                      HOMELESS                      NPH

OTHER: \_\_\_\_\_

CURRENT RENT: \$ \_\_\_\_\_ UTILITIES INCLUDED:    YES                      NO

PREVIOUS LANDLORDS, ADDRESSES, PHONE NUMBERS AND HOW LONG YOU RESIDED:

1) \_\_\_\_\_

2) \_\_\_\_\_

EMERGENCY CONTACT PERSON:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

HAVE YOU BEEN CONVICTED OF A FELONY WITHIN THE LAST FIVE (5) YEARS?    YES                      NO

In this section provide all information for your spouse or others living in your household (if applicable):

Full Name	Relationship	Sex	Age	Date of Birth
1) _____	_____	_____	_____	_____
2) _____	_____	_____	_____	_____
3) _____	_____	_____	_____	_____
4) _____	_____	_____	_____	_____

ARE YOU A STUDENT:                      YES                      NO

NAME & ADDRESS OF SCHOOL: \_\_\_\_\_

**Page 2**

ARE YOU EMPLOYED:                      YES                      NO                      If Yes, How Long: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ Phone #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

INCOME: Please list total income for all household members:

Income Source	Whose Income:	How Often Received	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

RESOURCES: Please list total monies available such as cash, checking, etc. for all household members.

Resource Owner	Resource Type	Bank Name & Address	Bank Phone #	Amount
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

DEDUCTIONS:

I pay for medical expenses (hospitalization, prescription drugs, etc.)	YES	NO	\$ _____
I have a spend-down for medications (Proof of spend-down is required)	YES	NO	\$ _____
Other:			\$ _____

DO YOU HAVE ANY OUTSTANDING LIENS:                      YES                      NO

I, \_\_\_\_\_, voluntarily consent to participate in the applicable NHDC Program. I understand that the income information I have provided is to be used only to consider my application for this program. I understand that a written copy of the program service description is available for my personal records upon request.

I have truthfully reported all income and assets received by all household members. All other information I have provided to NHDC is true to the best of my knowledge. I agree to report any income changes to New Home Development and to provide verification of such changes within ten (10) days of such change when this information is applicable to a specific program in which I am a participant.

**INITIAL IF THE FOLLOWING APPLIES:**

**If I receive a lump sum Social Security check intended for the time period I am involved in NHDC housing programs, I understand that a maximum of 35% of monthly income received in backpayment will be applied toward additional rent. I am to notify NHDC of receipt of such a check. Rent payments will be recalculated, based on income verification provided to NHDC.**

By my signature, I hereby certify that I have read and understand this application for housing assistance administered by New Home Development Co., Inc. I hereby agree to abide by these provisions.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**NEW HOME DEVELOPMENT CO., INC.**  
 617 N. Walnut St. #12  
 Bryan, OH 43506  
 Phone: 419-519-3075 Fax: 419-519-3042

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Client Information:**

Name	Date of Birth	Social Security Number	
Address	City	State	Zip

**Physician Information:**

Physician Name	Phone #	Fax #	
Address	City	State	Zip

**PHYSICIAN VERIFICATION OF DISABILITY**

The above named person has applied for assistance from New Home Development. Please fill out the verification of disability and/or impairment. Feel free to attach notes as necessary. Any information that you provide will be kept confidential. We are required to verify this information for all persons applying for assistance through our agency. Your prompt return of this information will be appreciated. **IMPORTANT:** Please read the following definition and circle Yes or NO with regard to this individual. Any other request for information about the individual is not relevant (e.g., diagnosis; treatment plan).

Please circle:  
**YES                      or                      NO**

**An adult 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 arrangement, 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 handicapped.**

Physician Signature	Date
Please Print Physician's Name	Address
	Phone

**CLIENT AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the above named organization/person to release information regarding me to New Home Development Co. for the reason shown below. I acknowledge and understand the PROHIBITION ON DISCLOSURE rule: ***"This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."*** I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that New Home Development cannot control the recipient's use of the information. I understand that I, and/or my guardian, if possible, may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. I understand that housing assistance cannot be conditioned upon my giving authorization for disclosure of information FOR ANY OTHER PURPOSE.

The purpose of this disclosure is for:

**VERIFICATION OF A MENTAL ILLNESS**

Signature of Client or Responsible Party	Relationship to Client	Date Signed
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