

In order to participate in housing programs administered by New Home Development, I understand that I must be diagnosed with a severe, chronic mental illness and receiving services from an ADAMhs Board Contract Agency. I also understand that NHDC uses state funds to assist with housing expenses. I acknowledge that all information I give is correct and true. I understand that giving any false information is considered fraud and is a prosecutable offense.

NEW HOME DEVELOPMENT COMPANY, INC.

617 N. Walnut, #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: _____	

My Current Housing Status is: Homeless _____ Sub-standard housing? _____ Living w/friend or family _____

Paying over 50% of income for rent? _____

Current Rent: _____ **Are the utilities included?** YES _____ NO _____

DO YOU HAVE A PAYEE? YES NO _____
 Payee Name: _____ Address _____ Phone _____

WHY DO YOU NEED HOUSING ASSISTANCE? _____

Please provide the name, address, phone number and length of time you rented from your current and previous landlords. I understand that my landlord will be contacted for a reference.

- 1) _____
 Name Address Phone Length of Residence
- 2) _____
 Name Address Phone Length of Residence

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)					

Have you attempted to find resources from other Community Agencies? YES _____ NO _____

Source and Amount of Aid Found: _____

Are you employed? YES NO If Yes, How Long: _____

EMPLOYER: _____ Phone #: _____

ADDRESS: _____

INCOME: Please list total income for all household members. I understand that I and all other adults in my household MUST be actively seeking an income in order to be considered for assistance from NHDC. I agree to report any income change to NHDC within 10 days of such change.

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

Do you have a bank account? YES _____ NO _____ Account Balance: _____

Please list your monthly financial obligations:

Bill	Amt	Bill	Amt	Bill	Amt	Bill	Amt	Bill	Amt
Electricity		Water		Phone		Medication		Other:	
Gas		Insurance		Child Support		Other:		Other:	

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:			\$

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.

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 40% 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. **I also understand that any false or untrue information given is considered fraud and is a prosecutable offense.**

Applicant's Signature

Date

Applicant's Signature

Date

NEW HOME DEVELOPMENT CO., INC.

617 N. Walnut, #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

Psychiatrist or Other Authorized Personnel Information:

Name	Phone #	Fax #	
Address	City	State	Zip

**PSYCHIATRIST OR AUTHORIZED PERSONNEL
VERIFICATION OF DISABILITY**

NHDC provides rental assistance for adults who suffer from chronic mental illness. In order to be considered for housing assistance, a diagnosis of a mental illness is required from the applicant's psychiatrist and the applicant must be receiving services from an ADAMhs Board Contract Agency. Please give the diagnosis code(s) for the above named applicant. Feel free to attach notes as necessary. Any information that you provide will be kept confidential.

**TO BE COMPLETED BY
PSYCHIATRIST OR AUTHORIZED PERSONNEL ONLY**

Diagnosis Code(s) is/are REQUIRED:

_____	_____	_____
Code	Code	Code
_____	_____	_____
Code	Code	Code

Comments: _____

NOTE: A person whose sole impairment is alcoholism or drug addiction does not qualify for housing assistance.

Signature of Psychiatrist or Authorized Personnel:

Title:	Date:
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CLIENT AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named psychiatrist 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.

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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Notice of Enrollment into the Multi-Agency Community Services Information System (MACSIS) and Authorization for Billing

To be eligible to receive public funds to help pay for the cost of your alcohol, drug addiction and/or mental health services, you will need to read and sign this statement that allows the agency to give demographic and billing information to the Four County ADAMhs Board and Behavioral Health Generations (BHG). Behavioral Health Generations is the entity that the Four County ADAMhs Board will use to enroll all clients in the Multi-Agency Community Services Information System (MACSIS) and process claims in compliance with state requirements.

Agencies will continue to use the Board approved sliding fee scale to determine what amount, if any, that you may be required to pay for services. If you are eligible for Medicaid or other public funds, then the agency will submit name identifying demographic and billing information to the Four County ADAMhs Board and BHG.

BHG will enroll you in the appropriate Four County ADAMhs Board behavioral healthcare plan. The Board will determine what public funds can be used to pay for your services, and pay the agency the appropriate contracted amount as calculated by an information system (MACSIS) connected with the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Human Services.

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL, consistent with state and federal law. Name identified information will only be used to pay for services received. Other information will be kept without your name attached. This information will not be available to any other sources or used for any other purposes. You have the right to review your records and notify the agency of errors in your record. Billing information will be kept for seven (7) years after you have received services, and only demographic information will be kept after that time.

If you do not agree to sign this disclosure and authorization form, then the Board may not be able to use public funds to pay for your services.

Agency Name: **New Home Development Company, Inc.**

I have read and understand the above and authorize the disclosure of name identifying billing information to the Four County ADAMhs Board and BHG.

Name of Client: _____
(please print name)

Client Social Security #: _____ Client Date of Birth: _____

Signature of Client/Guardian: _____

Date Signed: _____