

**Unified Supportive Housing System (USHS)
Prospective Applicant File Receipt**

Today's Date: _____

Dear Prospective Applicant:

Today you will be completing a Prospective Applicant File for the Unified Supportive Housing System (USHS).

What is USHS?

USHS is a collaborative effort managed by ADAMH, CMHA and CSB. These partners are working together with other agencies in the community to assist individuals who have long term disabilities and are experiencing literal homelessness. The goal is to find safe, decent and affordable Permanent Supportive Housing (PSH) for these vulnerable individuals, who may otherwise face housing barriers.

How do I know if I'm eligible?

Only those Prospective Applicants who are currently homeless, residing in a temporary emergency shelter, transitional housing or place not suitable for human habilitation and have a qualifying disability will be considered for referral.

You cannot be found eligible until we receive all required File documentation. Each File is valid for 6 months from your release of information signature date.

Please contact your Navigator/Case Manager with questions regarding application status. Please keep in regular contact with your Navigator/Case Manager to ensure that information is up-to-date, accurate and complete.

Is there a waiting list?

No, USHS does not use a waiting list, we use a prioritization pool. This means that applicants are separated into pools by homeless status and referred based on duration of homelessness, severity of service needs and availability of eligible units.

***CSB Disclaimer:** The Community Shelter Board (CSB) is a funder and does not have influence over the day to day decisions made at a Provider Agency. Each agency has its own program participant procedures. CSB can only forward concerns to the Provider Agency or Housing Provider and request a response (unless a major violation/incident has occurred).

Provider Agency Representative	Provider Agency	Contact Phone Number

**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.

Provider Agency Rep.	Printed Name	Signature	Date
	Provider Agency Name	Rep. Email Address	Rep Phone#

**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. 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) [REDACTED], 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 Indication of Interest.

- 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, 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.			

VI. 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.

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, and MACSIS, the database which is used by agencies in the Mental Health system.

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 Indication of Interest 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 Only ADAMH_Homeless

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):			
Will there be another adult residing with you in the household?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, Please give that person's name below:	
ADAMH Provider Agency:	<input type="checkbox"/> Amethyst Inc. <input type="checkbox"/> Columbus Area <input type="checkbox"/> Community Support Network <input type="checkbox"/> Comp Drug <input type="checkbox"/> Concord Counseling <input type="checkbox"/> Huckleberry House <input type="checkbox"/> Maryhaven <input type="checkbox"/> Mental Health and Addiction Services Ohio	<input type="checkbox"/> Nationwide Children's Hospital BHS <input type="checkbox"/> North Central Mental Health <input type="checkbox"/> North Community Counseling <input type="checkbox"/> Southeast Inc. <input type="checkbox"/> Southeast PATH Program <input type="checkbox"/> Syntero <input type="checkbox"/> TBI Network <input type="checkbox"/> Concord Counseling <input type="checkbox"/> <u>Not</u> linked to a provider on this list	
Case Manger Name:		Team: (If Applicable)	
Case Manager Email:		Case Manager Phone Number:	

Are you linked to any ongoing services not included in the list above (i.e. AOD, physical or mental health care, etc.)? <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes*		
*If Yes, Please Provide the following Information:		
Doctor/Provider Name:	_____	
Address:	_____	
Phone Number:	_____	
Race (Voluntary-Please Select One or More):		
<input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Multi-Racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Asian		
Ethnicity (Voluntary):		
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Latino	
Are you a US citizen or Legal US Resident?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status:		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Other _____
<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Domestic Partnership/Common-Law
Gender:		
<input type="checkbox"/> Male	<input type="checkbox"/> Transgendered Female to Male	<input type="checkbox"/> Other _____
<input type="checkbox"/> Female	<input type="checkbox"/> Transgendered Male to Female	
Are you Currently Pregnant?	If yes, what trimester are you in?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> 1 st (1-3 months) <input type="checkbox"/> 2 nd (4-6 months) <input type="checkbox"/> 3 rd (7-9 months)	

Fulltime Student?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you or a Member of your Family Require Special Accommodations?	If yes, please check yes and below which accommodation(s) you need:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wheelchair Accessible <input type="checkbox"/> No Steps <input type="checkbox"/> Few Steps <input type="checkbox"/> Handicap Accessible Parking	<input type="checkbox"/> Hearing disability <input type="checkbox"/> Grab bars and Handrails <input type="checkbox"/> Modification for vision or hearing impairment
Total Monthly Income:	\$	
Prospective Applicant Receives: (check all that apply)		
<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Disability Assistance <input type="checkbox"/> Pension/Veteran's Administration (Military Pay) <input type="checkbox"/> Wages from job	<input type="checkbox"/> Self-Employment <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Alimony <input type="checkbox"/> Educational Financial Assistance (Financial Aid)	<input type="checkbox"/> TANF/AFDC (Public Assistance) <input type="checkbox"/> Court-Ordered Child Support Payments Received <input type="checkbox"/> Informal Child Support Payments Received
Prospective Applicant Enrolled In: (check all that apply)		
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have You ever Served in the US Military?	If yes, what was the character of your discharge?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Honorable <input type="checkbox"/> Other than Honorable <input type="checkbox"/> General <input type="checkbox"/> Refused	<input type="checkbox"/> Medical <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable

Are you Eligible for Veteran Services?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused		
Prospective Applicant's Current Living Arrangement		
<input type="checkbox"/> Living in a place unintended for habitation (street, car, under bridge, in camp/on the land etc.)	<input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Hospital Medical Unit <input type="checkbox"/> Rental Housing <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Residential Care Facility	<input type="checkbox"/> Substance Abuse Treatment Facility <input type="checkbox"/> Doubled-up <input type="checkbox"/> Other _____
<input type="checkbox"/> Domestic Violence Situation		
<input type="checkbox"/> Living with Friends or Relatives		

***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

Date

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

Long Term (Chronic) Health Disorder

Yes No

Substance Use 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**

***Note: If your client is in Transitional Housing, they are automatically Eligibility A. Understanding that, please continue to fill out this form in its entirety.**

1. Using the LOS Calculator, please list the total cumulative homeless time this Prospective Applicant has:	<input style="width: 100px; height: 30px;" type="text"/>
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2. Based on CSP and/or Verification of Street Homelessness, has the Prospective Applicant been homeless for at least 120 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(If yes skip to Question #4)

3. Based on CSP and/or Verification of Street Homeless has the Prospective Applicant had 4 separate episodes of homelessness, which cumulatively add up to at least 120 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 If you answered No to both Questions #2 and #3 please see Option A and do not continue.

4. Based on CSP and/or Verification of Street Homelessness has the Prospective Applicant been homeless for <u>at least 12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(If yes see option C)

5. Based on CSP and/or Verification of Street Homelessness has the Prospective Applicant had 4 separate verifiable episodes of homelessness within 3 calendar years, which cumulatively add up to <u>at least 12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(If yes see option C)

 If you answered No to both Questions 4 and 5 please see Option B.

Preliminary Eligibility

A. Non-Rebuilding Lives Eligible	Your Prospective Applicant is not yet eligible for a Non-Rebuilding Lives unit and/or 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. HUD Chronic Eligible	Your Prospective Applicant is eligible for USHS and will be given priority over non-HUD chronic individuals in the pool. Upon referral please consider <u>all available</u> 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?

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
Rep.

Printed Name

Signature

Date

USHS
Program
Manager

Printed Name

Signature

Date

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Please include: Length of Stay (LOS) Print-Out

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Please include: Columbus ServicePoint
Entry/Exit Print-Out

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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?		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin <input type="checkbox"/> French <input type="checkbox"/> 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?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	<input type="checkbox"/> Refused
9. In the past year, how many times have you been hospitalized as an in-patient?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	<input type="checkbox"/> Refused
10. How many times have you been in jail or prison?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	<input type="checkbox"/> Refused
11. Where do you sleep most frequently?	<input type="checkbox"/> Shelters <input type="checkbox"/> Outside (Camp/Streets) <input type="checkbox"/> Car/Van/RV <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Treatment Facility/Hospital <input type="checkbox"/> Residential Care Facility	<input type="checkbox"/> Abandoned Home <input type="checkbox"/> With Friends or Family <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Your own home or apartment <input type="checkbox"/> Other

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

Substance Abuse	
25. Have you ever had problematic drug or alcohol use, abused drugs or alcohol or been told that you do?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
26. Have you consumed alcohol almost every day for the past month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
27. Have you ever used injection drugs or shots?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
28. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health	
30. Have you been ever told that you were diagnosed with a mental health issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
31. Are you currently or have you ever received treatment for mental health reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
32. Have you had a serious brain injury or head trauma that required hospitalization or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
33. Have you been ever told that you were diagnosed with a learning or developmental disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
OBSERVATION ONLY 34. Interviewer, do you observe signs of confusion, evidence of developmental disability, dementia, or memory impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Self-talk, distracted, paranoia, fear, phobic, depressed or manic)			
Significant Challenges and Functional or Social Impairments			
35. As a minor were you ever in foster care or abused or neglected by caregivers?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
36. Have you ever left home because of domestic violence?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
37. Do you have a permanent physical disability that limits your mobility? (i.e., wheelchair, amputation, unable to climb stairs)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
38. Have you been the victim of a violent attack since you've become homeless?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
39. Do you have any friends, family, or other people in your life you can count on?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
41. Do you have enough money to meet all of your expenses on a monthly basis?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
42. How do you make money?	<input type="checkbox"/> Work (earned income) <input type="checkbox"/> Work (under the table) <input type="checkbox"/> Plasma Center <input type="checkbox"/> Pension/ Retirement	<input type="checkbox"/> SSI <input type="checkbox"/> VA <input type="checkbox"/> SSDI/SSA <input type="checkbox"/> Unemployment Check <input type="checkbox"/> General Assistance	<input type="checkbox"/> No Income <input type="checkbox"/> Panhandling <input type="checkbox"/> Sex Work/Trade <input type="checkbox"/> Drug Trade <input type="checkbox"/> 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** please provide a copy of the ODJFS Benefits Printout.

For a **Veteran Unit** please provide documentation of Veteran's Benefits.