Time: _____

Extended Housing, Inc. is a 501(c)(3) nonprofit organization whose mission is to prevent and end homelessness for individuals in Lake County with serious mental illness.

APPLICANT MUST COMPLETE APPLICATION IN FULL. APPLICATION WILL NOT BE ACCEPTED UNTIL IT IS COMPLETE. ORIGINAL APPLICATION MUST BE HANDED IN BY PERSON OR MAILED - NO FAXES WILL BE ACCEPTED. EXTENDED HOUSING WILL THIRD PARTY VERIFY THROUGH A PSYCHIATRIST, PSYCHOLOGIST, OR NURSE PRACTITIONER FROM A BEHAVIORAL HEALTH AGENCY TO VERIFY DISABILITY.

APPLICANT NAME:

_____

LAST FIRST M.I.

ADDRESS: _____

STREET CITY STATE ZIP

HOME PHONE_____OTHER#_____

Name and Alias	Relation	Race	Sex	DOB	SS#	Veteran (Y/N)

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐

Citizenship: US Citizen ☐ Eligible Non-Citizen ☐

Last Grade Completed (please check below):

Grade 1 - 12	
College	
Vocational/Training	

LAKE COUNTY ADAMHS BOARD

EQUAL HOUSING OPPORTUNITY

APPLYING FOR:

☐ **HOUSING SUBSIDIES**— Units owned by private landlords *(Lake Co. Residents only)*

☐ **EXTENDED HOUSING PROPERTIES**—Owned and managed by Extended Housing *(Lake Co. Residents only)*

☐ **MCNAUGHTON APARTMENTS**—One-bedroom units.

If applying for any rental assistance or Extended Housing property, we encourage you to apply for a Housing Choice Voucher (Section 8) through Lake Metropolitan Housing Authority.

CURRENT HOUSING STATUS	PREFERRED HOUSING STATUS
☐ With Family/Friend	☐ Mentor
☐ Apartment/House	☐ Painesville/Fairport
☐ Shelter	☐ Perry/Madison
☐ Outdoors	☐ Willoughby/Willoughby Hills/Eastlake
☐ Jail	☐ Wickliffe/Willowick
☐ Treatment Facility	
☐ Other	

Present Landlord Name & Address: _____

Present Monthly Rent Amount: _____

List all previous landlords and addresses for the past two years. (May use separate sheet of paper.)	
Previous Landlord	**Previous Landlord**
NAME:	**NAME:**
PHONE:	**PHONE:**
PREVIOUS ADDRESS:	**PREVIOUS ADDRESS:**
CITY, STATE:	**CITY, STATE:**

All information in this application must be verified before an applicant can obtain housing through Extended Housing. Applicants will be required to present a birth certificate (original or certified copy) or a valid U.S. passport, or a baptismal record, or naturalization certificate, or military discharge papers. Additional verifications required are Social Security Cards for all household members, proof of all income (SSDI/SSI, child support, alimony, employment, workman's compensation, unemployment benefits.) All applicants are required to make known all alias names used so that a complete and accurate background check can be completed prior to the applicant's acceptance into any Extended Housing program or property.

FINANCIAL INFORMATION:

Guardian/Payee_____
(Name, address & phone)

Present Source of Income:
_____

Total amount of all monthly Income: _____ _ Annual Income: _____

Do you have a utility balance? ☐ Yes ☐ No (If yes, list company and amount) _____

MISCELLANEOUS INFORMATION:

As your application nears the top of the waiting list, Extended Housing, Inc. will complete a background check. If the report indicates criminal history, and/or history of drug or alcohol abuse within the last three years your application is subject for denial. If denied, applicant will be given an opportunity to request an informal hearing to present current status and participation in treatment or therapy programs.

Do you have special needs that impact your housing or need an accessible unit? ☐ Yes ☐ No

If yes, please describe: _____

Are any members of your household subjected to a lifetime sex offender registration? ☐ Yes ☐ No

Please list every state that each adult in your household has lived in._____

Have you ever been evicted? ☐ Yes ☐ No

(If yes, list reason) _____

Are you currently on LMHA's wait list for a Housing Choice Voucher (Section 8)? ☐ Yes ☐ No

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE MY APPLICATION WHENEVER THERE IS A CHANGE IN MY HOUSING STATUS AND WHEN EXTENDED HOUSING REQUESTS AN UPDATE.

I UNDERSTAND THAT FAILURE TO UPDATE MY APPLICATION WILL RESULT IN MY NAME BEING WITHDRAWN FROM THE WAITING LIST. I ALSO UNDERSTAND THAT ALL UPDATES MUST BE DONE IN WRITING IN ORDER TO MEET ALL REPORTING RESPONSIBILITIES.

SIGNED: _____ Date: _____

Applicant / Legal Guardian (if applicable)

****

I certify that the answers I have made to all of the questions in this application are true and complete to the best of my knowledge.

I authorize Extended Housing, Inc. to verify all information that may be released to appropriate Federal, State and Local agencies.

I understand that false statements or information are punishable under Federal Law.

It is understood that this information will be used solely for the purpose of determining my eligibility for assistance.

Applicant Signature_____ Date: _____

Guardian Signature (if applicable) _____ Date: _____

AFFIRMATIVE ACTION

We consider all applicants without regard to race, color, religion, sex, national origin, citizenship, age, or any other similarly protected status. We also comply with all applicable laws governing housing practices and do not discriminate on the basis of any unlawful criteria.

Office Use Only Income Level: ☐ Extremely Low Income ☐ Very Low Income ☐ Low Income

Date application entered into waitlist: _____

Housing Support Assistant Signature: _____

Removed Date: _____ Reason for Removal: _____

Rejected Date: _____ Reason for Rejection: _____

Move in Date: _____

EMERGENCY CONTACT RELEASE FORM

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**

PREAMBLE

Extended Housing, Inc. is a non-profit housing development corporation and contract agency of the Lake County Board of Alcohol, Drug Addiction, and Mental Health Services (ADAMHS). Extended Housing, Inc. serves as the developer of Lake County ADAMHS Board's permanent housing for its clients.

Extended Housing, Inc. maintains ownership of completed apartment buildings and provides property management services. In addition, Extended Housing provides homeless outreach services and manages several rental subsidy programs. All mental health and supportive social services are provided by case managers employed by county mental health center/agencies and any staff assigned to work in the community.

As a contract agency of the ADAMHS Board, Extended Housing, Inc. is committed to adherence to provisions of the Client Rights Policy of the Lake County ADAMHS Board that follows.

CLIENT RIGHTS

LAKE COUNTY BOARD OF ALCOHOL, DRUG ADDICTION AND MENTAL HEALTH SERVICES
CLIENT RIGHTS POLICY

For clients of our services certified by the Ohio Department of Alcohol and Drug Addiction Services, Extended Housing, Inc. recognizes, protects and promotes the following rights;

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy;

2. The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;

3. The right to receive services in the least restrictive, feasible environment;

4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;

5. The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;

6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;

7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;

8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures;

9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio

and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;

10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;

11. The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;

12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;

13. The right to be informed of the reason for denial of a service;

14. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

15. The right to know the cost of services;

16. The right to be verbally informed of all client rights, and to receive a written copy upon request;

17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;

18. The right to file a grievance;

19. The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;

20. The right to be informed of one's own condition; and,

21. The right to consult with an independent treatment specialist or legal counsel at one's own expense.

To protect and enhance the rights of those who apply for, or receive mental health services, the Alcohol, Drug Addiction and the Mental Health Board has developed a Grievance Procedure that addresses the alleged denial or abuse of Client Rights. Extended Housing, Inc. is committed to following this Grievance Procedure.

NAME	WITNESS
DATE	DATE

EXTENDED HOUSING

270 E. Main Street, Suite 300 • Painesville, Ohio 44077

(440) 352-8424 • (440) 942-9441 • Fax (440) 352-8421 • e-mail www.extendedhousing.org

Certification of Disability

Housing Subsidy/ Housing Loan Application

This form must be completed by a psychiatrist, psychologist, or a behavioral health agency's nurse practitioner. If applying for McNaughton Apartments, this form must be sent by Extended Housing to third party and sent back by third party to Extended Housing.

Name: _____

The above-named person is applying for participation in a housing assistance program operated by Extended Housing, Inc. To determine the applicant's eligibility, we must verify that they are Severely Mentally Disabled (SMD) or Severely Emotionally Disturbed (SED). A psychiatrist, psychologist or a behavioral health agency's nurse practitioner must complete this form. No other professional submissions will be accepted.

(Definitions and criteria for SMD and SED are on the back of this form)

A. _____ ☐ is SMD ☐ is not SMD
(Name of Person over the age of 18)

OR

B. _____ ☐ is SED ☐ is not SED
(Name of Child under the age of 18)

_____
Psychiatrist/Psychologist/Nurse Practitioner Certifying (print name)

_____
Occupation/Title

_____
Agency

_____
Address

_____
Phone

_____ _____
Signature of Psychiatrist, Psychologist, Nurse Practitioner Certifying Date

Person with serious emotional disturbance (SED): A person less than eighteen years of age who meets criteria that is a combination of duration of impairment, intensity of impairment and diagnosis:

(a) Criteria:
  (i) Under eighteen years of age;
  (ii) Marked to severe emotional/behavioral impairment;
  (iii) Impairment that seriously disrupts family or interpersonal relationships; and
  (iv) May require the services of other youth-service systems (e.g., education, human services, juvenile court, health, mental health/mental retardation, youth services, and others).

(b) Marked-to-severe behavioral impairment is defined as impairment that is at or greater than the level implied by any of the following criteria in most social areas of functioning:
  (i) Inability or unwillingness to cooperate or participate in self-care activities;
  (ii) Suicidal preoccupation or rumination with or without lethal intent;
  (iii) School refusal and other anxieties or more severe withdrawal and isolation;
  (iv) Obsessive rituals, frequent anxiety attacks, or major conversion symptoms;
  (v) Frequent episodes of aggressive or other antisocial behavior, either mild with some preservation in social relationships or more severe requiring considerable constant supervision; and
  (vi) Impairment so severe as to preclude observation of social functioning or assessment of symptoms related to anxiety (e.g., severe depression or psychosis).

(c) An impairment that seriously disrupts family or interpersonal relationships is defined as one:
  (i) Requiring assistance or intervention by police, courts, educational system, mental health system, social service, human services, and/or children's services;
  (ii) Preventing participation in age-appropriate activities;
  (iii) In which community (home, school, peers) is unable to tolerate behavior; or
  (iv) In which behavior is life-threatening (e.g., suicidal, homicidal, or otherwise potentially able to cause serious injury to self or others).

Person with severe mental disability (SMD): A person eighteen years of age or older with a severe mental or emotional disability who meets *at least two of the three* following criteria of diagnosis, duration, and disability:

(a) Diagnosis: the current primary diagnosis is delusional disorders (DSM IV 297.1); dissociative disorders (DSM IV 300.14); eating disorders (DSM IV 307.1, 307.51, 307.52); mood disorders (DSM IV 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 300.4, 301.13, 311); personality disorders (DSM IV 290.0, 290.10, 290.1x, 290.4x, 294.10, 294.80); personality disorders (DSM IV 301, 301.20, 301.22, 301.4, 301.50, 301.6, 301.7, 301.81, 301.82, 301.83, 301.9); psychotic disorders (DSM IV 295.40, 295.70, 298.9); schizophrenia (DSM IV 295.1, 295.2, 295.3, 295.6, 295.9); somatoform disorder (DSM IV 307.80); other disorders (DSM IV 313.23, 313.81, 313.82); or other specified.

(b) Duration: the length of the problem can be assessed by either inpatient or outpatient use of service history, reported length of time of impairment, or some combination, including at least two prior hospitalizations of more than twenty-one days or any number of hospitalizations (more than one) totaling at least forty-two days prior to the assessment, or ninety to three hundred sixty-five days in a hospital or nursing home within three prior years, or major functional impairment lasting more than two years, resulting in utilization of outpatient mental health services on an intermittent and/or continuous basis.

(c) Disability/functional impairment: severity of disability can be established by disruption in two or more life activities, including but not limited to: employment, contributing substantially to one's own financial support (not to be entitlements), independent residence, self-care, perception and cognition, stress management/coping skills, interpersonal and social relations.