



CHATHAM COUNTY HOUSING PROGRAM REQUIREMENTS

Eligibility Criteria

(1) DISABILITY

Applicants must have a primary diagnosis of one or more of the following:

- Serious Mental Illness
- Chronic Substance Abuse
- Developmental Disabilities

A person shall be considered disabled by this diagnosis if the impairment is expected to be of indefinite duration and is of such a nature that her/his disability could be significantly improved by more suitable housing conditions, and/or s/he would be at risk of hospitalization without improved housing.

(2) INCOME

Applicants must have a household income at or below the level of *very low income* (50% of the local median income) for the county in which the housing is located.

(3) ILLEGAL ACTIVITY

An applicant will be denied participation if s/he is incarcerated, on parole or probation, or if there is an outstanding warrant for her/his arrest.

Participation in the program will be terminated if the participant or a member of her/his household engages in illegal activity including domestic violence, illegal drug use, or other failure to abide by federal, state or local law.

(4) SUBSTANCE USE

Applicants with substance abuse history must substantiate a demonstrated period of sobriety (approximately 6 months).

(5) HOMELESSNESS

Some housing programs have an additional requirement of homelessness or imminent homelessness. Please verify whether specific homelessness definitions and/or requirements apply.

Referral Process

All applications must be supported and signed by a professional service provider, who is willing to fulfill the professional service provider requirements of the program (please refer to the section

below for a list of requirements). Applications are accepted on a first come, first serve basis. Send referrals to Vanessa Neustrom (fax 919-913-4001).

Requirements of Professional Service Providers and Participants

Before submitting an application, the referring professional service provider must ensure that the applicant meets the housing program eligibility criteria and is appropriate for and capable of independent living. Service providers must also develop or modify the treatment and/or person centered plan to identify any potential barriers to success in independent living. Once an applicant has been approved for the housing program, it will be the responsibility of the program participant and her/his service provider to pay for security deposits and utilities.

We have an obligation to meet specific grant requirements of each housing program. We also have an obligation to program participants, landlords and property managers to make every effort to assure successful residential placement. Consequently, professional service providers must adhere to the following requirements:

- To meet with participants regularly (it is recommended that all participants be seen at least weekly during their transition into the housing program, at least monthly during the first year of tenancy, and more frequently if necessary);
- To conduct home visits at least every other month during the participant's first year of tenancy, and more frequently if necessary;
- To engage in vocational or educational activities, such as but not limited to employment or employment searching, school, community service, if deemed able by the professional service provider;
- To report potential issues/problems to the housing coordinators;
- To act as a liaison between housing coordinators, participant and landlord, and to negotiate with the landlord as necessary;
- To provide a brief summary to the housing coordinators regarding the participant's status, at least quarterly for as long as participant continues to receive services;

Participants must adhere to the following requirements:

- To comply with treatment and/or services;
- To engage in ongoing recovery from substance abuse and agree to submit to periodic urine or breathalyzer testing as deemed necessary by professional service provider or housing coordinator;
- To permit professional service providers and the housing coordinators to make home visits as they deem necessary;
- To comply with the terms of the lease and/or occupancy agreement;
- To report any changes in income or family composition within 10 days;
- To allow professional service provider and housing coordinator to share information as needed;
- To allow professional service provider and housing coordinator to speak with the landlord as needed.

Professional service providers and applicants should retain a copy of the all requirements for future reference.

CHATHAM COUNTY Housing Program Agreement

Participant Agreement

I certify that I have received and read the Housing Program Requirements and that if selected for the program, I agree to comply with and fulfill the Participant Requirements, set forth herein.

Head of Household

Date

Professional Service Provider Agreement

I certify that I have received and read the Housing Program Requirements and, if the participant is selected for the Housing Program, I will comply with the Professional Service Provider Requirements set forth herein. *If I am unable to fulfill these requirements, I will actively work with the participant to engage another professional treatment provider who is able to meet all Professional Service Provider Requirements.*

Professional Service Provider

Date

Return this signed form to OPC.

For OPC Use Only

Date Received:

CHATHAM COUNTY HOUSING PROGRAM APPLICATION

Please return to:
OPC Local Management Entity
Housing Specialist
100 Europa Dr. #490
Chapel Hill, NC 27517
(919) 913-4139
fax: (919) 913-4001



Date of Application: _____

Applicant Name: _____

Current Address: _____

City, State, Zip: _____ Telephone: _____

Service Provider Name: _____

Agency: _____

Current Address: _____

City, State, Zip: _____ Telephone: _____

Household Composition and Characteristics (Information required by HUD)

1. List the Head of Household and all others who will be living in the unit. Give the relationship of each member to the Head of Household.

Member's Full Name	Relationship	Birthday	Age	Sex	Soc. Sec. #
	HEAD				

2. Does anyone other than those listed above currently live with you? ____ YES ____ NO

3. Do you plan to have anyone who is not listed above live with you in the future?
____ YES ____ NO (If yes, please describe)

4. Is the head of household or adult partner disabled? ____ YES ____ NO (If yes, please explain)

5. Are any other household members disabled? ____ YES ____ NO (If yes, please explain)

6. Do any members of your household have special housing needs? ____ YES ____ NO (If yes, please explain.)

7. Are you now living in housing subsidized by federal, state or local government? ____YES
____NO (If yes, provide the name of the complex and the name and telephone number of
the manager.)

8. Are you a U.S. veteran? ____YES ____NO

9. Please check if you identify as:

Asian/Pacific Islander____ Black/African American____ Latino/a____ Native Am.____
White____ Other____

10. Are you a "chronically homeless" person as specifically defined by HUD (see definition
below)? ____YES ____NO

An unaccompanied homeless individual with a disabling condition who has either been continuously
homeless for a year or more OR has had at least four episodes of homelessness in the past three years.
To be considered chronically homeless, a person must have been on the streets or in an emergency
shelter (i.e. not in transitional housing) during these stays.

Disabling Condition-"A diagnosable substance use disorder, serious mental illness, developmental
disability, or chronic physical illness or disability, including the co-occurrence of two or more of these
conditions. A disabling condition limits an individual's ability to work or perform one or more activities
of daily living".

Income and Asset Information

Please answer each of the following questions. For any question to which you answer "yes,"
provide further information below and, if you need additional space, on the last page of this
application. Do you or any member of your household:

YES NO

- | | | |
|------|------|--|
| ____ | ____ | 1. Work full-time, part-time or seasonally? |
| ____ | ____ | 2. Expect to work for any period of time during the next year? |
| ____ | ____ | 3. Expect a leave of absence from work due to lay-off, medical,
maternity or military leave? |
| ____ | ____ | 4. Now receive or expect to receive unemployment benefits? |
| ____ | ____ | 5. Now receive or expect to receive child support? |
| ____ | ____ | 6. Entitled to child support that child is not receiving? |
| ____ | ____ | 7. Now receive or expect to receive alimony? |
| ____ | ____ | 8. Entitled to alimony that is not being received? |
| ____ | ____ | 9. Now receive or expect to receive public assistance, including Work
First? |
| ____ | ____ | 10. Now receive or expect to receive Social Security Disability benefits? |
| ____ | ____ | 11. Now receive or expect to receive Social Security Retirement benefits? |
| ____ | ____ | 12. Now receive or expect to receive income from a pension or annuity? |
| ____ | ____ | 13. Now receive or expect to receive regular financial contributions from
any organization or individual? |
| ____ | ____ | 14. Receive income from assets including interest on checking or savings
accounts, interest and dividends from certificates of deposit, stocks, bonds,
or income from rental property? |
| ____ | ____ | 15. Own real estate or have a checking account or any other assets
(including stocks, bonds, IRA's, CD's, other funds, or cash) for which you |

_____ receive no income?
 _____ 16. Have you sold or given away real property or other assets (including cash) in the past two years?

Family Member	Source of Income/Type of Income/Asset	Market Value	Annual Income

Family Member	Bank Name	Type of Account	Account Number	Balance

Expenses

YES NO

- _____ 1. Do you have expenses for child care of a child aged 12 or younger. (If yes, provide the name, address and telephone number of the provider, and the weekly cost of child care.)
- _____ 2. Do you pay for a care attendant or equipment for a handicapped or disabled household member in order to permit that person or someone in the household to work? (If yes, provide the name, address and telephone number of the provider, and the weekly cost of the attendant or equipment.)
- _____ 3. Do you have Medicare? (If yes, what is your monthly payment?)
- _____ 4. Do you have any type of medical insurance? (If yes, what is the policy number and name, address and telephone number of the company?)
- _____ 5. Do you have medical or pharmacy bills which exceed 3% of your annual income? (If yes, what is the name, address and telephone number of your medical provider and/or pharmacy?)

References

1. Please provide the name, address and telephone number of two personal references. You may list the name of a relative or someone who knows you well:

Name	Relationship	Address	Telephone

2. Please provide the name, address and telephone numbers of your last two landlords (include your current landlord, if applicable), how long you lived at each location and your reason for leaving:

Name	Address	Telephone	Duration of tenancy	Reason for leaving

3. Please provide the names, addresses and telephone numbers of your last three places of employment. Include your job title, supervisor's name, dates of employment, rate of pay, and your reason for leaving:

Name, Address & Phone	Job Title	Supervisor	Dates Employed	Pay	Reason for leaving

4. Please provide the name, relationship, address and telephone number of your nearest relative **not** living with you:

Name	Relationship	Address	Telephone

5. Please provide the name, relationship, address and telephone number of the person to be contacted in an emergency:

Name	Relationship	Address	Telephone

Medical History

1. Please provide the names, addresses and telephone numbers of your community support provider, primary care physician, therapist, psychiatrist, psychologist, case manager, social worker, and other treatment providers (use the last page of this application or additional paper if necessary):

Name	Type of Provider (e.g. therapist)	Agency	Address & Telephone

2. Do you have any current medical/psychiatric issues? ____Yes ____No

If yes, please provide your diagnosis:

3. Are you taking any medications? Yes No (If yes, please list the name, dosage, frequency, and condition for which you are taking the medication.)
4. What is your history of compliance with taking medications?
 Good Fair Poor (If poor, please explain.)
5. Have you had a psychiatric hospitalization in the past 5 years? Yes No (If yes, please provide the date(s) of each hospitalization, the length of stay and whether it was voluntary or involuntary.)

Date and Length of Stay	Voluntary or Involuntary

6. Have you ever done anything dangerous to others or tried to hurt another person?
 Yes No (If yes, please describe the specific behavior, the approximate date that it happened and the outcome of the incident.)
7. Have you ever done anything dangerous to yourself or tried to hurt yourself?
 Yes No (If yes, please describe the specific behavior, the approximate date that it happened and the outcome of the incident.)
8. Have you ever done anything to damage or destroy property?
 Yes No (If yes, please describe the specific behavior, the approximate date that it happened and the outcome of the incident.)
9. Are you currently using substances (alcohol or drugs)? Yes No
10. Do you have a history of substance abuse? Yes No

If yes to question 9 or 10, please list all substances used, when you used them, and what if any treatment you receive now or have received (including AA or NA):

Substance Used	Approximate Dates of Use	Approximate Duration of Use	Treatment , Including Program and Dates

Approximate date of most current use:

Approximate dates and lengths of periods of sobriety:

Space for additional information below from previous pages:

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fax: (919) 913-4001



Verification of Disability (to be completed by professional service provider)

For the purpose of this program, the applicant/tenant must meet the following criteria:

a) As a result of her/his disability, the need for treatment is expected to be of a long, continued, and indefinite duration; b) The disability substantially impedes her/his ability to live independently; and c) The disability is of such a nature that it could be improved by more suitable housing conditions. If the participant is disabled by chronic problems with alcohol and/or drugs, the problematic use must have occurred for at least 12 months and caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

In my opinion, the applicant/tenant, _____ is disabled as defined above. Specifically, s/he meets the criteria of the following (please circle only one, which is the primary diagnosis):

1-Serious Mental Illness

2-Chronic Substance Abuse (CSA)

3-Serious Mental Illness AND Chronic Substance Abuse

4-AIDS

5-Developmental Disability

Signature (professional qualified to diagnosis)

Title

Print Name

Date

Organization & Address

Telephone

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Employment Verification

Applicant/Tenant: _____

_____ To the best of my knowledge, this form is not applicable to applicant/tenant.

Signature of Service Provider

Date

Confidential Employment Information: (to be completed and verified by employer--please answer all questions that apply)

1. **Date employment began:** _____
2. **Occupation/Position:** _____
3. **Date of termination:** _____
4. **Rate of regular pay:** _____ **per** _____
5. **Average hours worked per week:** _____
6. **Deductions from pay (e.g. health insurance):** _____

Signature of Verifier

Title

Print Name

Date

Organization & Address

Telephone

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Verification of Homelessness

Applicant/Tenant: _____

Please check the appropriate description. **Supporting documentation to demonstrate that the applicant is homeless/chronically homeless must be attached.**

I hereby certify that the above applicant for housing is homeless or at imminent risk of becoming homeless because s/he resides in one of the places or under conditions described below:

- _____ In places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings (“on the street”);
- _____ In an emergency shelter or crisis apartment;
- _____ In transitional or supportive housing for homeless persons who originally came from the street or emergency shelters (evidence is required that the person came from the streets or emergency shelter situation);
- _____ In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution;
- _____ Is being evicted within a week (7 days) from a private dwelling unit and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing;
- _____ Is being discharged within a week (7 days) from an institution, such as a mental health or substance abuse treatment facility in which s/he has been a resident for more than 30 consecutive days and no subsequent residence has been identified, and lacks the resources and support network needed to obtain housing;
- _____ Is being released from prison/jail with no subsequent residence identified and lacks the resources and support network needed to obtain housing;
- _____ Is fleeing a domestic violence housing situation, with no subsequent residence identified, and s/he lacks the resources and support network needed to obtain housing;
- _____ Is living in substandard housing that has been condemned.
- _____ **CHRONICALLY HOMELESS:** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been on the streets or in an emergency shelter (i.e. not in transitional housing) during these stays.

 Signature of Verifier _____
 Title

 Print Name _____
 Date

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Verification of Income/Benefits

Applicant/Tenant: _____

I am able to certify that I receive the following monthly income.

Type(s) of Income/Benefit: _____

Monthly Income/Benefit: _____

Duration it is expected to continue: _____

Deductions: _____

I understand that I must attach documentation that verifies the above information (i.e. pay stub, Social Security Administration statement, etc.)

I certify that the above information represents all my current sources of income. The information that I provided is accurate and true. I understand that I will not be accepted into the Shelter Plus Care Program if I provide false information. I also understand that if accepted into the Shelter Plus Care Program, I must inform the coordinator of this program of any changes in my income within ten days.

Signature of Applicant/Participant

Date

To the best of my knowledge, the information provided by the named applicant is accurate and true.

Signature of Service Provider

Date

