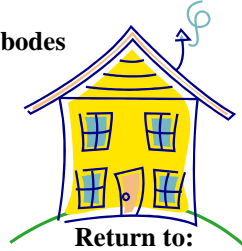


OPC Local Management Entity
Shelter Plus Care Program
Administered by:
Community Alternatives to Supportive Abodes

The Chrysalis Foundation for Mental Health
Supportive Housing Program



Return to:
100 Europa Drive, Ste. 490
Chapel Hill, NC 27517
Fax: 919-913-4001
Phone: 919-913-4139

Housing Application Checklist

Client Name: _____

Applications will not be processed until all items listed below are received

- Clean Time (*six months required*)
- SHP-SPC Application (*signed by client and service provider*)
- SHP-SPC Program Requirements (*signed by client and service provider*)
- Disability verification form (*signed by client and doctor*)
- Homeless verification form
- Homeless letter of verification (*needs to be dated seven days within the interview*)
- Verification of Employment
- Verification of Guardianship
- Consent Form from OPC and CASA (*can be signed at interview*)
- Applicants on Probation should also complete a consent form to include the following: OPC, CASA, Therapist, Probation Officer
- Checklist of Basic Health & Safety Skills (*completed at interview*)
- Treatment Plan to include goal that addresses housing and/or independent living
- Copy of Income verification (*SSI, SSDI reward letter, pay stubs, etc.*)
- If referral is for an adult with children and one or more of the children are receiving mental health services, please insure that this is a joint referral, submitted by the child's therapist/case manger and the adult's therapist/case manager. Please include a treatment plan for the child, showing the services that the child will receive while he/she is living in OPC/Chrysalis-owned or managed housing.
- Has applicant applied for a Section 8 Voucher with Orange Housing Authority?**

If you have any questions please contact Vanessa Neustrom at 913-4139 or VNeustrom@opc-mhc.org



Shelter Plus Care and Supportive Housing Program **REQUIREMENTS**

Shelter Plus Care (SPC) and the Supportive Housing Program (SHP) is a HUD grant program, funded through the Orange County Continuum of Care, that provides permanent housing assistance, in connection with supportive services, to homeless people with disabilities and their families. For each grant period, the grantee must demonstrate that the services provided to program participants, in the aggregate, are equal to or greater than the value of the total amount of the grant.

SPC is tenant-based rental assistance within Orange County which permits participants to choose housing of a size based on household composition. SPC will pay a housing subsidy based on a participant's income and the rental amount (SPC will approve subsidies for units that rent at or near "fair market rent" as determined by HUD guidelines). Participants retain the rental assistance if they move and continue to meet the program requirements.

SHP allows the Chrysalis Foundation to lease subsidized units to participants. The rental amount is based on the participant's income and requires a \$250 security deposit. Utilities will be included in your rental payment.

Eligibility Criteria

(1) HOMELESSNESS

For purposes of this program, a person is considered homeless only when s/he resides in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings ("on the street");
- In an emergency shelter;
- 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 living in substandard housing that has been condemned.

CHRONICALLY HOMELESS: An unaccompanied homeless individual with a disabling condition who has 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 emergency shelter (i.e. not in transitional housing) during these stays.

(2) DISABILITY

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

- Serious Mental Illness
- Chronic Substance Abuse
- Developmental Disabilities
- AIDS

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 such ability could be improved by more suitable housing conditions. The Verification of Disability form must be signed by a psychiatrist, psychologist, or MD qualified to determine whether an individual is disabled.

(3) INCOME

Applicants must have a household income at or below the level of *very low income* for Orange County, as determined by HUD.

(4) CRIMINAL BACKGROUND

An applicant will be denied participation if s/he is incarcerated 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.

(5) SUBSTANCE USE

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

Referral Process

All applications must be 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 comprehensive outline of requirements). To make a referral for SPC, you may the OPC Housing Coordinator at (919) 913-4000 to request an application. Applications are accepted on a first come, first serve basis. When a participant is at the top of the waiting list, they will be interviewed by the Resident Screening Committee and then referred to CASA, who will be the contract agency responsible for administering the SPC Program on behalf of OPC. Supportive Housing applications will be referred to the Chrysalis Foundation after being screened and approved.

Requirements of Professional Service Providers and Participants

Before submitting an application, the referring professional service provider should verify that the applicant meets the SPC eligibility criteria and is appropriate for and capable of independent living. Service providers must 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, with assistance from her/his service provider to locate rental housing, provide a security deposit and arrange for 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:

- Update the treatment/person centered plan to reflect housing goals;
- Assist the participant in filling out all required paperwork and acquiring supplemental verification to ensure eligibility for the program (i.e. pay stubs, bank statements)
- Work with the participant to locate rental housing, meet with the landlord as necessary and act as a point of contact for the landlord;
- To meet with participants regularly as necessary (it is recommended that all participants be seen at least weekly during their transition onto the SPC/SHP 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 report potential issues/problems to the housing coordinator;
- To act as a liaison between CASA (contract agency), the participant, and landlord, and to negotiate with the landlord as necessary;
- To provide a brief summary to CASA regarding the participant's status, at least quarterly for as long as participant continues to receive services;

- To complete all billing/reporting of services for SPC/SHP participants in a timely manner and provide billing records to OPC when requested.

If you are unable to fulfill these requirements, you must actively work with the participant to engage another professional treatment provider who is able to meet all SPC Professional Service Provider Requirements. The participant will not be accepted into the program until there is a Professional Service Provider in place that agrees to fulfill the program requirements.

SPC/SHP participants must adhere to the following requirements:

- To comply with treatment and/or services;
- To engage in ongoing recovery from substance abuse;
- To agree to submit to periodic urine or breathalyzer testing, as deemed necessary by professional service provider, Chrysalis Foundation, OPC housing coordinator, Resident Screening Committee or CASA staff;
- 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 permit professional service providers, Chrysalis Foundation staff, OPC housing coordinator or CASA staff to make home visits as they deem necessary;
- To comply with the terms of the lease and occupancy agreement;
- To report any changes in income or family composition within 10 days;
- To allow professional service provider, Chrysalis Foundation staff, OPC housing coordinator or CASA staff to speak with the landlord as needed (as specified in a signed consent to release information).

PLEASE NOTE:

Professional service providers and applicants should retain a copy of the SPC/SHP Requirements for future reference.

SPC/SHP Program Requirement 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 that if the participant is selected for the SPC/SHP Program, I will comply with the Professional Service Provider Requirements set forth herein.

Professional Service Provider

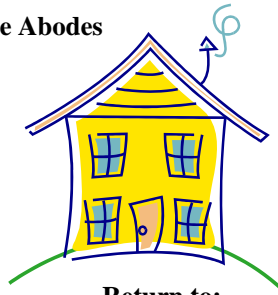
_____ Date

Please submit this page with the application for housing.

OPC Local Management Entity
Shelter Plus Care Program

Administered by:
Community Alternatives to Supportive Abodes

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Supportive Housing Program



Return to:
Housing Coordinator
100 Europa Drive, Ste. 490
Chapel Hill, NC 27517
Fax: 919-913-4001
Phone: 919-913-4139

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, including children? YES NO (If yes, please explain)
6. Are you now living in federally subsidized housing? YES NO (If yes, provide the name of the complex and the name and telephone number of the manager.)
7. Do any members of your household have special housing needs? YES NO (If yes, please explain.)
8. Are you a U.S. veteran? YES NO
9. Please check if you identify as:
Native Am. Black White Asian/Pacific Islander Latino/a
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 on the grids 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 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 (e.g. cocaine)	Time & Duration of Use (e.g. 10/99 for 6 months)	Treatment (e.g. IOP)

Approximate date of most current use:

Approximate dates and lengths of periods of sobriety:

Space for additional information below from previous pages:

Applicant Certification

I certify that if selected to receive SPC/SHP assistance, the unit I occupy will be my only residence. I authorize the owner, manager, and program representative to verify all information provided. I certify that the statements made and information provided are true and complete to the best of my knowledge and belief. I understand that false statements or misrepresentations are punishable under Federal law.

Head of Household

Date

Household Member Over 18

Date

Professional Service Provider Certification

I certify that to the best of my knowledge and belief, this applicant meets basic eligibility criteria for the SPC/SHP program.

Professional Service Provider

Date

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Phone: 919-913-4139

Verification of Disability

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

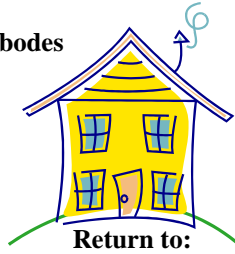
Organization & Address

Telephone

**The Verification of Disability form must be signed by a psychiatrist, psychologist, or MD qualified to determine whether an individual is disabled.

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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 SPC/SHP housing is 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;
- _____ 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 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

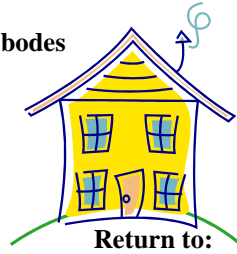
Organization & Address

Telephone

****Supporting documentation should be on letterhead from the homeless shelter or outreach worker.**

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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

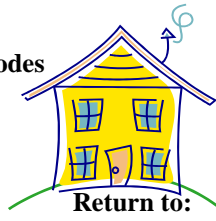
To the best of my knowledge, the information provided by the named applicant is accurate and true.

Signature of Service Provider

Date

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Legal Guardian Verification

Applicant/Tenant: _____

_____ The applicant/tenant does NOT have a legal guardian.

Signature of Applicant/Tenant

Date

_____ The applicant/tenant does have a legal guardian.

Name of Legal Guardian: _____

Mailing Address: _____

Signature: _____

Print Name: _____

Title: _____

Organization: _____

Address: _____

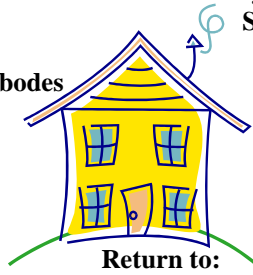
Telephone: _____

Date: _____

NOTE: Applicants/tenants cannot verify this form if they have a legal guardian. Should an applicant have a legal guardian, the legal guardian is the recommended verifier. If the legal guardian is not available, a program representative can verify this form.

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 Chapel Hill, NC 27517
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 Phone: 919-913-4139

Verification of Social Security Income (to be completed if you receive SSI/SSDI)

To: Social Security Administration
 3004 Tower Blvd.
 Durham , NC 27707

Re: Applicant/Tenant: _____
 Social Security No.: _____

The person named above is an applicant/tenant for a dwelling in a U.S. Department of Housing and Urban Development (HUD) program. We are required by Federal Law to obtain verification of Social Security income in order to determine her/his eligibility for this program. We ask for your prompt cooperation in providing the following information to us at the address listed above.

I authorize the Social Security Administration to release the information requested below to the OPC Housing Coordinator.

 Applicant/Tenant _____
 Date

Please provide the following information:

- 1. **Monthly Social Security Benefit:** _____
- 2. **Supplemental Security Income:** _____
- 3. **Recipient's date of birth:** _____
- 4. **Deductions (e.g. health insurance) :** _____

 Signature _____
 Title

 Print Name _____
 Date

 Address _____
 Telephone

