

Time: \_\_\_\_\_



EXTENDED HOUSING, INC. IS A PRIVATE NON-PROFIT AGENCY, WHICH PROVIDES SAFE, DECENT, AND AFFORDABLE HOUSING FOR LOW-INCOME PERSONS AND FAMILIES EXPERIENCING MENTAL ILLNESS, INCLUDING THE HOMELESS.

**APPLICANT MUST COMPLETE ALL ITEMS IN FULL. A MENTAL HEALTH WORKER MUST COMPLETE VERIFICATION OF ELIGIBILITY. APPLICATION WILL NOT BE ACCEPTED UNTIL APPLICATION IS COMPLETE.**

APPLICANT NAME:

\_\_\_\_\_  
 LAST FIRST M.I.

ADDRESS:

\_\_\_\_\_  
 STREET CITY STATE ZIP

HOME PHONE \_\_\_\_\_ OTHER# \_\_\_\_\_

**List all members who will be living with you, start with yourself:**

LAST NAME	FIRST NAME	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY #	VETERAN Y/N

Head of Household:  White  Black  Hispanic  American Indian  Asian  
 Multiracial

Citizenship:  US Citizen  Eligible non-citizen

**APPLYING FOR:**

- SUBSIDIES—Units owned by private landlords and subsidized by Lake Co. ADAMHS Board & ODMH
- EXTENDED HOUSING—Properties owned and managed by Extended Housing
- MCNAUGHTON APARTMENTS—Two bedroom units for single individuals – roommate situation

**If applying for any subsidy or Extended Housing property, we encourage you to apply for a Section 8 voucher through Lake Metropolitan Housing Authority.**



CURRENT HOUSING STATUS	PREFERRED HOUSING STATUS
_____ With Family	_____ Mentor
_____ Apartment/House	_____ Painesville/Fairport
_____ Shelter	_____ Perry/Madison
_____ Outdoors	_____ Willoughby/Eastlake
_____ Jail	_____ Wickliffe/Willowick
_____ Treatment Facility	_____ Rent
_____ Other	_____ Own Home

Present Landlord: Name & Address: \_\_\_\_\_

Present Monthly Rent Amount: \_\_\_\_\_

**Please list all previous landlords and addresses for the past 2 years. (If you need more space please include on separate sheet of paper.)**

Previous Landlord	Previous Landlord
Name _____	Name _____
Telephone Number _____	Telephone Number _____
Previous Address _____ _____	Previous Address _____ _____
Move in date _____ Move out date _____	Move in date _____ Move out date _____

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:**

Present Source of Income: \_\_\_\_\_

Gross Monthly Income: \_\_\_\_\_ (Total amount of all income) Annual Income: \_\_\_\_\_

Do you have a utility balance? \_\_\_\_\_ If yes, list company and amount \_\_\_\_\_

Guardian/Payee \_\_\_\_\_  
(Name, address & phone)

**MISCELLANEOUS INFORMATION:**

**Management will reject an applicant due to unacceptable behavior when there is a history of drug or alcohol abuse and the household member is not currently participating in a treatment or therapy program.**

Do you have special needs that impact your housing? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Do you need an accessible unit? \_\_\_\_\_

Illicit drug or excessive alcohol use? \_\_\_\_\_ If yes, current extent of problem: \_\_\_\_\_

Legal involvement history? \_\_\_\_\_ If yes, list charges and dates \_\_\_\_\_

Have you ever been evicted? \_\_\_\_\_ If yes, list reasons \_\_\_\_\_

Have you applied for Section 8? \_\_\_\_\_

**\*\*Please answer the following questions only if you have applied for McNaughton Apartments\*\***

Annual Income: \_\_\_\_\_

Would you prefer your roommate to be a person whom:

Did not drink alcohol \_\_\_\_\_ occasionally drank alcohol \_\_\_\_\_

Pick one: \_\_\_\_\_ Do you sleep all night and up during the day or \_\_\_\_\_ sleep all day and up all night

**Extended Housing, Inc. makes all roommate assignments without regard to race, creed, natural origin or disability.**

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE MY APPLICATION WHENEVER THERE IS A CHANGE IN MY HOUSING STATUS. 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: \_\_\_\_\_

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 agree to permit my Community Support Worker/Mental Health Worker, and Extended Housing Inc. to consult with the Inter-Agency Housing Team to determine my eligibility for the programs I have applied for and to make necessary and reasonable interventions to preserve the safety, sanitation, and permanence of my rent subsidy and/or housing situation. I permit Extended Housing Inc. to consult with previous and prospective landlord(s) for the purpose stated above. 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: \_\_\_\_\_

Extended Housing, Inc., Staff Signature \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE TO APPLICANT**

If a unit becomes available and is offered to you, and you refuse for whatever reason, your name is then moved, as of that date, from your current place on the waiting list, down to the bottom of the waiting list. This makes your new date of application, the actual date of your refusal.

**All applications that have been inactive for two years or longer will be destroyed and removed from the waiting list database.**

**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.

**For Office Use Only**

Income Level:      ELI \_\_\_\_\_      VL \_\_\_\_\_      LI \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Removed Date: \_\_\_\_\_

Rejected Date: \_\_\_\_\_

Move In Date: \_\_\_\_\_

## Verification of Eligibility

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 he/she is Severely Mentally Disabled (SMD) or Severely Emotionally Disturbed (SED). Please have a professional such as your case manager, counselor, psychiatrist, or family doctor fill out one of the following:

(Definition and criteria of SMD and SED is on the back of this form)

A. \_\_\_\_\_ ( ) is ( ) is not SMD

OR

B. \_\_\_\_\_ ( ) is ( ) is not SED

Person Certifying (Print Name) \_\_\_\_\_

Occupation/Title \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



**“Person with serious emotional disturbance (SED)” means 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).

**“Persons with severe mental disability (SMD)” means 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 IIR 297.10); dissociative disorders (DSM IIR 300.14); eating disorders (DSM IIR 307.10,307.15, 307.52); mood disorders (DSM IIR 296.3x, 296.4x, 296.5x, 296.6x, 296.70, 300.40, 301.13, 311.00); personality disorders (DSM IIR 290.0, 290.0, 290.10, 290.1x, 290.4x, 294.10, 294.80); personality disorders (DSM IIR 301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.84, 301.90); psychotic disorders (DSM IIR 395.40, 295.40, 295.70, 298.90); schizophrenia (DSM IIR 295.1x, 295.2x, 295.3x, 295.6x, 295.9x); somatoform disorder (DSM IIR 307.80); other disorders (DSM IIR 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.