The following documents are required for the Advance Housing referral packet (for a CoC referral):

- Resident Application for Housing (attached)
- Background Check Consent (attached)
- SRAP Application (needed for agency-owned housing, not needed for HUD McK) (attached)
- SRAP Certification of Disability (needed for agency-owned housing, not needed for HUD McK) (attached)
- Documentation of Homelessness (use chronic homelessness checklist even if not chronic) (attached)
- Social Security Award Letter for current year (if not on SSI or SSD, inform agency to determine other acceptable income verification)
- Birth Certificate
- Social Security Card
- Photo ID (current)
- Verification of Disability (attached)
- Psychiatric Evaluation from within the past year

Additional Note: Consumers must have a primary diagnosis of a chronic mental illness (schizophrenia, schizoaffective disorder, major depressive disorder - recurrent, bipolar disorder, etc.).

Advance Housing, Inc. RESIDENT APPLICATION FOR HOUSING

Mail To: 100 Hollister Road

Teterboro, New Jersey 07608

The information provided on this application will be used to determine your eligibility to become a resident. Answer all questions on this application. Enter "None" or "N/A" for those questions which do not apply to you. Applications will not be considered unless they are fully completed. Please ask someone from our office if you need help to complete this form.

APPLICANT INFORMATION

Applicant's Name	Social Security Number	
Date of Birth	(Area Code) Telephone #	
Gender: Male Female Marital Status: □Single □Married □Separated □D	ivorced □Widow	
Are you a citizen of the United States? If not, do you have permanent resident status? Country of citizenship?	□Yes □Yes	
Racial Ethnicity: □African American □Asian □C native □Native Hawaiian or other Pacific Islander		
Are you a United States Veteran?	□Yes	□No
Do you claim handicapped or disabled status for elig If yes, is it of long term continued and indefinite dur	•	
Do you require special accommodations in your dwe If yes, what kind? □Physical □Visual □ Audit	•	□No
Have you ever been convicted of a felony or misdem □Yes □No If yes, please explain:		ation?
Will you consider shared living?	□Yes	□No
Do you have a pet? If yes, what type:	□Yes	□No

Current living arrangement: □ Homeless □Shelter Other:	□Room □Apartment □Gr	oup Ho	me
Reason for leaving?			
If you are homeless, how long have you been home	less?		
How many times in the last 3 years have you been I	nomeless?		
			
Do you currently have a Housing Voucher or a Sect	ion 8 Certificate?	□Yes	□No
Are you receiving Temporary Rental Assistance?		□Yes	□No
If yes, when does it expire?			
What is your total annual income?	Source of income?		
Do you have any assets? (i.e. checking, savings, IR	A, 401K) If so list type of asse	et and a	nnual
income.			
Has there ever been a judgment, foreclosure, bad de	ebt, or collection against you?	□Yes	□No
Have you ever been evicted?		□Yes	
If yes to either question, please explain:			
Y			
In case you are unable to be reached, please provide			
Name: Relation Relati	onsnip to you:		
i none number(s)			
Who referred you to this agency?			
AGREEM	FNT		
I am requesting an application for a rental with Advance on this application are true, correct and complete and the Advance Housing, Inc. can request a credit check, a back and disability verification to assist in determining my information, it may be used as grounds to deny my application.	e Housing, Inc. I certify that all hat all income has been listed. Aground check, income verification eligibility and that if I have falson.	I underson, hous	stand that ing status
Signature [Date		
This data and all data received by the management relati	ive to income of applicant is rega	arded as	being

confidential in nature and protected accordingly to the extent permitted by law.

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Rental Application Form

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Advance Housing, Inc. 100 Hollister Road Suite 7 Teterboro, NJ 07608

Authorization to Release Information / Screening Consent Form

The state of the s	In connection with my rental / employment application. I understand that background inquiries may be requested on myself, including but not limited to consumer retail credit reports, driving records, criminal background checks, landlord/tenant records, rental and employment history, bank account balances and any other information deemed necessary in evaluating my application.	:
1	I hereby authorize without reservation National Tenant Network or any party or agency contracted to furnish the above referenced information and release all parties from any ability and responsibility from doing so. I hereby consent to obtaining the above information from National Tenant Network and any of their agents (or agency contracted). This authorization shall be valid in original or fax form. I further authorize ongoing procurement of the above mentioned reports when requested.	***************************************
	· V	
F	Applicant Name	
F	Applicant Signature	
Ε	Date: 🔼	

SRAP PROJECT-BASED ASSISTANCE PROGRAM

CERTIFICATION OF DISABILITY

Applicant's Name:	
• •	

The above named person is applying for participation in the SRP Project -Based Assistance Program administer by the New Jersey Department of Community Affairs. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the U.S. Department of Housing and Urban Development (HUS). HUD regulations define disability as follows:

- A. A person with a physical, mental, or emotional impairment that:
 - 1. Is expected to be of long continued and indefinite duration;
 - 2. Substantially impedes his or her ability to live independently; and
 - 3. Is of such a nature that such ability could be improved by more suitable housing conditions.
- B. A severe, chronic, developmental disability which;
 - 1. Is attributable to mental or physical impairment or combination of mental and physical impairments;
 - 2. Is manifested before the person attains age twenty-one;
 - 3. Is likely to continue indefinitely;
 - 4. Results in substantial function limitations in three or more of the following area of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and
 - 5. Reflects the person's need for a combination of and sequence of special, interdisciplinary, or generic care, a treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicate	ed.
(Please check the definition(s) that applies) [] A; [] B; and describe your patient's condition:	
Estimated duration that the disability will continue:	
Physician's Name:	
Physician's License Number:	
Address:	
Telephone Number:	
Physician's Signature:	
Date of Signature :	
Client Authorization Date	

Advance Housing, Inc. Verification of Disability

Date:			
To:		From:	Gina Gaffney, LPC, ACS Name of Sender
	Address		Clinical Director Title of Sender
		····	Advance Housing - Sussex Address
Re:(Individual C	laiming Disability	<i>i</i>)	

The above-named person participates in a federally-assisted program operated by Advance Housing, Inc. To continue to assist this person, we must verify that he/she is disabled as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

- A. A person with a physical, mental, or emotional impairment that:
- 1. Is expected to be of long continued and indefinite duration;
- 2. Substantially impedes his or her ability to live independently; and
- 3. Is of such a nature that such ability could be improved by more suitable housing conditions

OR

- B. A severe, chronic developmental disability which:
- 1. Is attributed to mental or physical impairment or combination of mental and physical impairments:
- 2. Is manifested before the person attains age twenty-two;
- 3. Is likely to continue indefinitely;
- 4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and
- 5. Reflects the person's need for a combination of and sequence of special, interdisciplinary, or generic care, a treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

Please complete the Certification of Disability and return it at your earliest convenience.

Sincerely, Gina Gaffney, LPC, ACS, Clinical Director Signature

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Advance Housing, Inc. Certification of Disability

(Individual Claiming Disability)
I certify that the above referenced person is disabled according to the above definition(s) I have indicated.
(Please check the definition(s) that applies)
[X]A []B
and describe your patient's condition:
DIAGNOSIS:
Estimated duration that disability will continue: <u>Indefinitely</u>
Physician's Name:
Physician's License Number:
Address:
Telephone Number:
Physician's Signature:
Date of Signature:

Advance Housing, Inc. - Sussex Chronic Homelessness Documentation Checklist

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family).

Client Name:	Date of Birth:
Number in Household:	Client Head of Household: ☐ Yes ☐ No
Part 1: Current Housing Status	
Client must currently be in one of these locations in of Client is currently residing: In Emergency Shelter On the Streets/Place not Meant for Human Habitation In the Safe Haven In an Institutional Care Facility (Where they have	ation
Start Date:	End Date:
Location Name/Address:	
Current Housing Status Notes:	
Chronic Homelessness Documentation Che	cklist - Page 1 of 4 (Not including Attachments)

Part 2:	Part 2: Housing History	istory						***************************************				
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Part 3: Disability Status
The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that • Is expected to be long-continuing or of indefinite duration; • Substantially impedes the individual's ability to live independently; • Could be improved by the provision of more suitable housing conditions; and • Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; • Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or • Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.
The head of household has been diagnosed with one or more of the following (check all that apply):
☐ Substance use disorder
☐ Serious mental illness
☐ Developmental disability
☐ Post-traumatic stress disorder
\square Cognitive impairments resulting from brain injury
☐ Chronic physical illness or disability
□ Other:
Documentation Attached:
\square Written verification of the disability from a licensed professional;
\square Written verification from the Social Security Administration;
\square The receipt of a disability check; or
☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.
Disability Notes:
Chronic Homelessness Documentation Checklist - Page 3 of 4 (Not including Attachments)

Part 4: Stail and Cheft Certifications		
Client Certification:		
To the best of my knowledge and ability, all the inforunderstand that any misrepresentation or false infortermination of assistance. It is my responsibility to not address in writing during program participation a	mation may result in my participation mation may result in my participation of	on being cancelled or denied, or in any changes in my housing status
Client Name: (Printed)	Client Signature:	Date:
Staff Certification:		
To the best of my knowledge and ability, all of the indetermination is true and complete.	formation and documentation used	in making this eligibility
Staff Name: (Printed)	Staff Signature:	Date:
Staff Role:	Agency:	
Notes:		
Chronic Homelessness Documentation Checklist - Page 4 of 4 (Not including Attachments)		