COMMUNITY HOUSE

A home for persons with disabilities.

Dear: _____

Thank you for your interest in Community House at St. Thomas, a family-style adult shared residence, located in Old Bridge, NJ. Community House can accommodate eight adults with physical disabilities, who are self-directed and mentally competent. The home has four single rooms and two double rooms.

This document has two parts.
1. Pre-application: eligibility requirements and questionnaire
2. Application for residence

For residency consideration both parts must be completed and returned to:

Susan A. Kuzma, Supervisor
Community House at St. Thomas
124 Bentley Ave
Old Bridge, NJ 08857

Please review your answers, make sure the entire packet is complete and return it to me at the above address. This will ensure that your application is processed quickly and accurately. If you have a disability and need assistance with the application process, please contact Susan Kuzma at 732-251-0022.

Thank you,

Susan A. Kuzma, Supervisor
www.communityhouse-saintthomas.org

Community House eligibility requirements:

1. Meet HUD income guidelines, demonstrating very low-income and be willing to pay the rent according to HUD guidelines.

2. Meet age guidelines, at least 18 years when you take residency.

3. Are not receiving and are not eligible for services from the Division of Developmental Disabilities.

4. Must have a medically-documented severe physical disability.

5. Have chronic disabilities with one or more conditions that cannot be substantially eliminated through generally accepted medical procedures.

6. Have undergone complete diagnostic procedures and received definite medical, surgical and/or rehabilitative services to stabilize the acute phase of the illness or disability.

7. Must submit a complete medical clearance form from a licensed physician indicating they are free from communicable disease and not in need of nursing care or require services not available in such a boarding house. Community House does not provide any medical services.

8. Are mentally alert, communicative, and have the ability to control and direct the fulfillment of their own needs are able to be their own guardian.

9. Have a service profile which indicates an ability to manage their own money, direct their own care, and provides that they are eligible for supervised care, if needed, i.e., home health aid/personal attendant services from Personal Attendant Services, N.J. Care or Medicaid waiver programs.

10. Show evidence of motivation and ability to participate in community living and are willing to share resources for personal attendant care.

11. Need 20 hours or less of personal assistance per week.

12. Capable of self-evacuation with or without assistive devices in less than three minutes, as certified by a licensed physician. No mechanical lifts will be used in Community House at St. Thomas.

13. Not in need of nursing care, as certified by a licensed physician.

14. Capable of self-medication without supervision.

15. Provide documented proof of social security number within sixty days of certification.

16. Must submit to a criminal background check upon application as per HUD guidelines and every two years thereafter.

17. The unit must be the applicant's only residence.

18. Must sign the Authorization for Release of Information and all information relevant to eligibility and level of assistance must be verified.

19. Must volunteer and/or participate in vocational or educational activities within the greater community at least 20 hours per week.

Individuals with any of the following will not be accepted:

- ☐ Reasonable cause to believe the applicant is engaging in active or current substance and/or alcohol abuse
- ☐ Any history of sexual predation
- ☐ Active TB or other communicable disease
- ☐ Psychiatric diagnosis or history of behavioral problems. (Community House does not provide treatment for psychiatric diagnoses or behavioral problems)
- ☐ Respirator dependent
- ☐ Comatose
- ☐ Terminal stages of illness
- ☐ Current active seizure disorder
- ☐ Current involvement in drug-related criminal activity, violent criminal activity, or criminal activity that would threaten the health, safety, or right to peaceful enjoyment of the premises by other residents, employees, or vendors. Individuals who have engaged in such activities during a reasonable time period prior to application will also be denied admission.

Applicants who do not meet these guidelines will be referred back to the hospital or agency, which provided or is currently providing treatment and assistance. After admission, a referral shall be made to the county welfare board for transfer to a facility suitable to meet a resident's needs if the resident ceases to meet eligibility requirements at any time after admission to Community House.

If, at any point after admission, the resident no longer meets the eligibility requirements, this lease shall terminate in accordance with HUD regulations and New Jersey law.

DEPARTMENT OF COMMUNITY AFFAIRS (DCA) Bureau of Rooming and Boarding House Standards

- 5:27-3.5 Appropriate placement

  (a) No licensee shall accept as a resident in a boarding house a person who not capable of self-evacuation with or without assistive devices, who is not certified by a licensed physician, or by a licensed nurse practitioner or licensed clinical nurse specialist legally authorized to issue such certification, to be free of communicable disease and not in need of nursing care or who requires services not available in such boarding house.

  (b) In the event that a resident ceases to be capable of self-evacuation acquires a communicable disease or requires nursing care, supervision of self-administration of medication or services not available in the rooming or boarding house, it shall be the responsibility of the licensee to so notify the county welfare board forthwith so that the resident may be transferred to a facility suitable to his or her needs.

  (c) A licensee who has reason to believe a resident to be in need of health or social services shall forthwith refer such resident to an appropriate agency.

- Is at least18 years of age at the start of residency.
- Meet the financial requirements set by HUD based on the most recently available guidelines.

COMMUNITY HOUSE

A home for persons with disabilities.

INITIAL INFORMATION AND REQUEST FOR APPLICATION FOR RESIDENCY

A. NAME: _____ SOCIAL SECURITY# _____

ADDRESS: _____ BIRTHDATE/AGE: _____/____

_____ TELEPHONES: _____

_____ _____WORK

COUNTY: _____ _____E-MAIL

A. NATURE OF DISABILITY: _____

_____

_____

FUNCTIONAL LIMITATIONS:

_____MOBILITY
_____HEARING
_____VISION
_____COGNITIVE
_____SPEECH
_____OTHER/SPECIFY _____

C. SOURCES OF INCOME:

_____EMPLOYMENT
_____WORKMANS COMPENSATION
_____SSI
_____SOCIAL SECURITY
_____PRIVATE INSURANCE
_____SETTLEMENT, TRUST, ETC.
_____OTHER _____

MEDICAL COVERAGE:

_____MEDICARE
_____MEDICAID
ID# _____
_____VA
_____PRIVATE INSURANCE
_____OTHER/SPECIFY _____
_____

AMOUNT OF ESTIMATED ANNUAL INCOME:

_____$0-5,000
_____$15,000-30,000
_____$5,000-15,000
_____ABOVE $30,000

D. CURRENT LIVING ARRANGEMENT:

_____INDEPENDENTLY (ALONE)
_____IN ROOMING/BOARDING HOME
_____WITH RELATIVES
_____WITH NON-RELATIVES
_____MEDICAL CARE FACILITY (ALL TYPES) Please specify

E. CURRENT EMPLOYMENT STATUS:

_____IN PAID EMPLOYMENT
_____UNEMPLOYED LOOKING FOR JOB
_____LOOKING FOR VOLUNTEER POSITION
_____UNEMPLOYED, UNABLE TO WORK AT THIS TIME
_____UNEMPLOYED, NOT INTERESTED IN WORKING
_____PREPARING FOR EMPLOYMENT (SCHOOL, ON-THE JOB, COLLEGE ETC.)
_____IN VOLUNTEER POSITION
_____HOMEMAKER

EQUAL HOUSING OPPORTUNITY

Catholic Charities
DIOCESE OF METUCHEN

124 Bentley Ave. • Old Bridge, NJ 08857 • (732) 251-0022 • Fax: (732) 251-3482

United Way
United Way of Central Jersey

F. PRESENT HOME CARE SERVICES USED/AVAILABLE:

RESOURCE TYPE:	NUMBER OF HOURS RECEIVED PER WEEK:
_____DDD	_____
_____MEDICAID PERSONAL CARE	_____
_____MEDICAID HOME HEALTH	_____
_____MEDICARE HOME HEALTH	_____
_____TITLE XX HOMEMAKER SERVICES	_____
_____VA (AIDE & ATTENDANT BENEFITS)	_____
_____OTHER SPECIFY	_____
_____PRIVATE ARRANGEMENT (SELF PAY TO AGENCY OR INDIVIDUAL)	_____
_____PASP	_____
TOTAL HOURS RECEIVED PER WEEK:	_____

ASSISTANCE FROM RELATIVES/INFORMAL CAREGIVERS:

_____ASSISTANCE USED/AVAILABLE	_____ASSISTANCE UNAVAILABLE
_____TOTAL HOURS RECEIVED PER WEEK	
	REASON(S) FOR UNAVAILABILITY
_____FAMILY/CAREGIVER INAPPROPRIATE	_____FAMILY/CAREGIVER UNWILLING
_____FAMILY/CAREGIVER NOT PRESENT	_____FAMILY/CAREGIVER UNABLE

G. TYPE OF PERSONAL ASSISTANCE SERVICES NEEDED/USED:

_____DIRECT PERSONAL CARE	_____MEAL PREPARATION
_____TRANSPORATION/MOBILITY	_____HOUSEKEEPING
_____CHORES/ERRANDS	_____OTHER _____

ASSISTIVE DEVICES USED:

_____W/C POWER	_____CANE/WALKER
_____W/C MANUAL	_____COMMUNICATION DEVICE
_____ HOYER LIFT	_____SERVICE ANIMAL

Do you or any member of your household have a disability as defined in Section 223 of the Social Security Act? Yes _____ No_____ If so, do you or any member of your household require a reasonable accommodation, i.e. a wheelchair accessible unit, grab bars, a service animal or etc.? If so, please indicate:

_____

_____

_____

H. Circle one in each "a" and "b". (For statistical purposes only)

. a. Is the head of the household (applicant)? :

American Indian or Alaskan Native Asian Black or African.

Native Hawaiian or Other Pacific Islander White

b. Ethnicity of the head of household.

: Hispanic or Latino Not Hispanic or Latino

I. Please provide a list of all previous addresses. You may use a separate sheet of paper if necessary.

1._____

2._____

3._____

4._____

5._____

6._____

8._____

9._____

10._____

APPLICANT CERTIFICATION: I certify that the statements made on this pre-application are true and complete to the best of my knowledge and belief. I understand that by providing false statements or in complete information may result in punishment under Federal Law.

DATE: _____/____/_____

SIGNATURE: _____

COMMUNITY HOUSE

A home for persons with disabilities.

APPLICATION FOR RESIDENCY AT COMMUNITY HOUSE

NAME: _____

ADDRESS: _____

_____

PHONE: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

Please review your answers, make sure the entire packet is complete and return it to me at the above address. This will ensure that your application is processed quickly and accurately. If you have a disability and need assistance with the application process, please contact Susan Kuzma at 732-251-0022.

Please provide a **brief autobiographical sketch** in the space below. (Feel free to continue on the back of this sheet or to attach another sheet if you need more room.) In it please describe your functional strengths and weaknesses as well s your degree of independence. What do you need help with? What are your aspirations and goals?

SELF DIRECTION QUESTIONAIRE

APPLICANT NAME: _____

DATE: _____

COUNTY: _____

INSTRUCTIONS: /the following are a set of questions related to managing personal assistance and situations common to independent living. Please give your own answers to these questions. You are being asked to analyze situations, and how you would instruct your personal assistant to do certain tasks. Be as specific as possible giving your answers. The questionnaire will be used by the evaluator to determine your ability to direct and manage a personal assistant.

1. If you were advertising for a personal assistant, describe the steps you would take to complete this task, and include places/locations you would consider to find one.

2. A person had responded to your ad. Briefly describe the nature of your disability, what your physical limitations are, and what tasks the personal assistant would be asked to perform.

3. List the qualities that you would look for in hiring and/or selecting a personal assistant and give reasons as to why these qualities are important to you.

4. Please give the following information on two of the prescription medicines you are currently taking. If you are not currently taking prescription medication, please disregard this question.

- Name of drug.
- Reason for taking drug.
- How often taken.
- Side effects known to you.
- Name of the physician prescribing the medication.

5. Describe the current make-up of your household (names, ages, and occupation.)

6. Please describe what household management duties you are responsible for?

7. If your personal assistant were unable to work for the next week, what alternate plan(s) would you devise to cover this lapse in service?

8. Your personal assistant is doing your food shopping for the first time. Describe the instructions you would give in order for your personal assistant to complete this activity.

9. If you were not satisfied with the performance of your personal assistant, what steps would you take to rectify the problems?

10. Do you have a disability as defined in Section 223 of the Social Security Act? Yes _____ No_____ If so, do you require a reasonable accommodation, i.e. a wheelchair accessible unit, grab bars, a service animal or etc.? If so, please indicate:

_____

If you move to Community House, will you need a place for your vehicle?
___YES___NO

Do you have any experience with shared living arrangements? If so, please describe that experience briefly.

What are your contingency plans for living arrangements if Community House doesn't work out for you?

To complete the application process, a visit to the home will be made at a mutually convenient time.

Forms are enclosed for the references, which will be **required before the home visit:**

- Medical form from your physician.
- Medical form from your physical/occupational therapist (if you are in therapy.).
- A personal reference from someone you know from work, school, or volunteer services.
- A personal reference from a family member or friend.

We also ask you **to bring to the home visit.**

1. Your personal assistance plan to obtain the services you need.
2. Your cash management plans demonstrating that you are able to be self-supporting.
3. Your activity plan for spending the 20 hours of volunteer work, education, or employment outside the house per week.

Please submit this application by_____ to: **Susan a Kuzma, Supervisor**
Community House at St. Thomas
124 Bentley Ave.
Old Bridge, NJ 0885

Signature: _____

Date: _____

Community House at St. Thomas Corporation

APPLICATION REFERENCE FORM

PERSONAL REFERENCE FOR:

NAME

ADDRESS

TELEPHONE NUMBER

CHECK ONE:

- FAMILY MEMBER OR FRIEND
- COLLEAGUE FROM WORK OR SCHOOL/VOLUNTEER SERVICE

NAME OF REFERENCE

ADDRESS

TELEPHONE NUMBER

I GIVE MY PERMISSION FOR THE COMMUNITY HOUSE SUPERVISOR AND REVIEW TEAM TO CONTACT MY REFERENCE WITH ANY ADDITIONAL QUESTIONS. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE OF APPLICANT

TO BE COMPLETED BY REFERENCE:

- IN WHAT CAPACITY DO YOU KNOW THIS APPLICANT? _____

- HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

- WHAT ACTIVITIES DO YOU PARTICIPATE INTOGETHER? _____

- DO YOU THINK COMMUNITY HOUSEWOULD BE NEFICIAL FOR THIS APPLICANT? _____

- WHY? _____

- WHAT DO YOU THNK THIS PERSON CAN CONTRIBUTE TO LIFE AT COMMUNITY HOUSE? _____

- HOW DO YOU VIEW THE APPLICANT'S CURRENT LIVING SITUATION? _____

Community House at St. Thomas Corporation

APPLICATION REFERENCE FORM

PERSONAL REFERENCE FOR:

NAME

ADDRESS

TELEPHONE NUMBER

CHECK ONE:

- FAMILY MEMBER OR FRIEND
- COLLEAGUE FROM WORK OR SCHOOL/VOLUNTEER SERVICE

NAME OF REFERENCE

ADDRESS

TELEPHONE NUMBER

I GIVE MY PERMISSION FOR THE COMMUNITY HOUSE SUPERVISOR AND REVIEW TEAM TO CONTACT MY REFERENCE WITH ANY ADDITIONAL QUESTIONS. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE OF APPLICANT

TO BE COMPLETED BY REFERENCE:

- IN WHAT CAPACITY DO YOU KNOW THIS APPLICANT? _____

- HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

- WHAT ACTIVITIES DO YOU PARTICIPATE INTOGETHER? _____

- DO YOU THINK COMMUNITY HOUSEWOULD BE NEFICIAL FOR THIS APPLICANT? _____

- WHY? _____

- WHAT DO YOU THNK THIS PERSON CAN CONTRIBUTE TO LIFE AT COMMUNITY HOUSE? _____

- HOW DO YOU VIEW THE APPLICANT'S CURRENT LIVING SITUATION? _____

COMMUNITY HOUSE AT ST. THOMAS CORPORATION

MEDICAL CLEARANCE FORM

APPLICANT/PATIENT NAME: _____

ADDRESS: _____

TELEPHONE _____ DATE OF BIRTH _____

PHYSICIAN NAME: _____

ADDRESS: _____

AREA OF SPECIALIZATION: _____

TELEPHONE _____ FAX _____

- HOW LONG HAS APPLICANT BEEN YOUR PATIENT? _____
- DIAGNOSIS: _____
- CURRENT CONDITION: _____
- PROGNOSIS: _____

B/P _____ Pulse _____ RR _____ PPD _____ Date _____ Results _____

- IS PATIENT/APPLICANT FREE OF COMMUNICABLE DISEASES? _____ YES _____ NO
- IS PATIENT/APLICANT IN NEED OF NURSING CARE? _____ YES _____ NO
- IS PATIENT/APPLICANT CURRENTLY BEING TREATED FOR OR HAS A HISTORY OF DRUG/ALCOHOL ABUSE? _____ YES
- NO _____
- IS PATIENT/APPLICANT CURRENTLY BEING TREATED FOR OR HAS A PSYCHIATRIC DIAGNOSIS OR A HISTORY OF
- BEHAVIORAL PROBLEMS? _____ YES _____ NO
- IN THE EVENT OF AN EMERGENCY IS APPLICANT CAPABLE OF SELF-EVACUATION WITH OR WITHOUT ASSISTIVE DEVICES? _____ YES ____ NO ***

*** PER NJ DEPARTMENT OF COMMUNITY AFFAIRS (NJDCA) Bureau of Rooming and Boarding House Standards:

5:27-3.5 Appropriate Placement

"(a) No licensee shall accept as a resident in a boarding house a person who is not capable of self-evacuation with or without assistive devices, who is not certified by a licensed physician, or by a licensed nurse practitioner or licensed clinical nurse specialist legally authorized to issue such certification, to be free of communicable disease and not in need of nursing care or who requires services not available in such boarding house.

(b) In the event that a resident ceases to be capable of self-evacuation, acquires a communicable disease or requires nursing care, supervision of self-administration of medication or services not available in the rooming or boarding house, it shall be the responsibility of the licensee to so notify the county welfare board forthwith so that the resident may be transferred to a facility suitable to his other needs.

(c) A licensee who has reason to believe a resident to be in need of health or social services shall forthwith refer such resident to an appropriate agency." Continued...

APPLICANT/PATIENT NAME: _____

- ASSESSMENT OF PATIENT'S/APPLICANT'S ABILITY TO DIRECT HIS/HER OWN CARE:, _____
- _____
- ASSESSMENT OF PATIENT'S/APPLICANT'SABILITY TO SELF-MEDICATE _____ _____

  _____
- ASSESSMENT OF APPLICANTS ABILITY TO COMMUNICATE AND RECOGNIZE HIS OR HER OWN NEEDS._____

  _____
- PLEASE ELABORATE ON HOW PROGNOSIS IMPACTS APPLICANT'S ABILITY TO RESIDE IN A SHARED LIVING ENVIROMENT_

  _____
- _____
- _____

APPLICANT NEEDS 20 HOURS A WEEK OR LESS FOR HOME HEALTH AID SERVICES. _____Yes_____ NO

HISTORY OF HOSPITALIZATION OVER THE LAST FIVE YEARS:

- WHERE: _____
- DIAGNOSIS: _____
- LENGTH OF STAY: _____

MEDICATION LIST

CURRENT MEDICATIONS/ DOSAGE /FREQUENCY	CURRENT MEDICATIONS/ DOSAGE /FREQUENCY
ALLERGIES TO MEDICATIONS	
ALLERGIES ENVIROMENTIAL	

APPLICANT/PATIENT NAME: _____

Resident Eligibility

Admission into Community House will be predicated on screening and clear, objective criteria. The criteria are as follows:

1. Meet HUD income guidelines, demonstrating very low income and be willing to pay the rent according to HUD guidelines.
2. Meet age guidelines, at least 18 years when you take residency.
3. Are not receiving and are not eligible for services from the Division of Developmental Disabilities.
4. Must have a medically documented severe physical disability.
5. Have chronic disabilities with one or more conditions that cannot be substantially eliminated through generally accepted medical procedures.
6. Have undergone complete diagnostic procedures and received definite medical, surgical and/or rehabilitative services to stabilize the acute phase of the illness or disability.
7. Must submit a complete medical clearance form from a licensed physician indicating they are free from communicable disease and not in need of nursing care or require services not available in such a boarding house. Community House does not provide any medical services.
8. Are mentally alert, communicative, and have the ability to control and direct the fulfillment of their own needs are able to be their own guardian.
9. Have a service profile which indicates an ability to manage their own money, direct their own care, and provides that they are eligible for supervised care, if needed, i.e., home health aid/personal attendant services from Personal Attendant Services, N.J. Care or Medicaid waiver programs.
10. Show evidence of motivation and ability to participate in community living and are willing to share resources.
11. Need 20 hours or less of personal assistance per week.
12. Capable of self-evacuation with or without assistive devices in less than three minutes, as certified by a licensed physician. No mechanical lifts will be used in Community House at St. Thomas.
13. Not in need of nursing care, as certified by a licensed physician.
14. Capable of self-medication without supervision.
15. Provide the necessary documentation to verify social security number within sixty days of certification.
16. Must submit to a criminal background check upon application as per HUD guidelines and every two years thereafter.
17. The unit must be the applicant's only residence.
18. Must sign the Authorization for Release of Information and all information relevant to eligibility and level of assistance must be verified.
19. Must volunteer and/or participate in vocational or educational activities within the greater community at least 20 hours per week.

Individuals with any of the following will not be accepted:

- ☐ Reasonable cause to believe the applicant is engaging in active or current substance and/or alcohol abuse
- ☐ Any history of sexual predation
- ☐ Active TB or other communicable disease
- ☐ Psychiatric diagnosis or history of behavioral problems. Community House does not provide treatment for psychiatric diagnoses or behavioral problems
- ☐ Respirator dependent
- ☐ Comatose
- ☐ Terminal stages of illness
- ☐ Current active seizure disorder
- ☐ current involvement in drug-related criminal activity, violent criminal activity, or criminal activity that would threaten the health, safety, or right to peaceful enjoyment of the premises by other residents, employees, or vendors. Individuals who have engaged in such activities during a reasonable time period prior to application will also be denied admission.

Applicants who do not meet these guidelines will be referred back to the hospital or agency, which provided or is currently providing treatment and assistance. After admission, a referral shall be made to the county welfare board for transfer to a facility suitable to meet a resident's needs if the resident ceases to meet eligibility requirements at any time after admission to Community House.

If, at any point after admission, the resident no longer meets resident eligibility requirements, this lease shall terminate in accordance with HUD regulations and New Jersey law.

I hereby certify that I have read and understand the foregoing eligibility requirements. I further certify that I meet these eligibility requirements. I will provide Community House at St. Thomas with all necessary documents and records proving that I satisfy these eligibility requirements. I acknowledge that if, at any point, I no longer meet the eligibility requirements of Community House at St. Thomas, my lease with Community House at St. Thomas shall terminate and I shall have to find alternate housing.

_____ _____

Signature **Date**

DOES THE PATIENT/APPLICANT HAVE ANY EXCLUSIONARY CRITERIA THAT MAY PRECLUDE THE PATIENT/APPLICANT FROM BEING A RESIDENT AT COMMUNITY HOUSE AT ST.THOMAS

Name & Credential of Health Care Professional (PRINT)

X _____ _____

Signature of Health Care Professional Date

COPY FORM AS MANY TIMES AS NEEDED FOR EACH DOCTOR/CLINICIAN

Catholic Charities, Diocese of Metuchen

CRIMINAL HISTORY RECORD INFORMATION AUTHORIZATION
COMMUNITY HOUSE AT ST. THOMAS

I, _____, understand that as part of my application for residency in Community House at St. Thomas, a criminal history background investigation must be performed on me as per HUD guidelines. Inconsideration of Catholic Charities' review of my residential application, I consent and allow Catholic Charities or its authorized agents bearing this Authorization or a copy of this Authorization to perform a criminal and background/reference investigation on me. I also authorize Catholic Charities or authorized agents to contact any individual or organization that might be relevant to my desired residency. Such individuals and organizations are authorized to release such information as may be requested by Catholic Charities or its authorized agents. I understand that the report may include any or all of the following:

Personal Identity Verification
Criminal History Records including fingerprint submissions to the New Jersey State Police and the Federal Bureau of Investigation

I authorize all persons and organizations, including law enforcement agencies, courts and creditors that may have information concerning this background information to disclose such information to Catholic Charities and its authorized agents. I hereby release Catholic Charities, its authorized agents, and all persons and organizations providing information from all claims and liabilities of any nature in connection with this investigation. I hereby further authorize that a photocopy or facsimile copy of this Authorization shall have the same force and effect as the original Authorization.

I understand that if the background check reveals criminal activity, my application for residency in Community House at St. Thomas may be denied. I further understand that only I can apply directly to the New Jersey State Police and receive from them a full text of my criminal history. Catholic Charities will only have access to a letter from the State Police indicating without explanation whether or not I have a conviction that may disqualify me from residing at Community House at St. Thomas.

I understand that I have specific prescribed rights under the Federal Credit Reporting Act (FCRA) and may have additional rights under relevant state law. I hereby certify that I have been informed of, and presented with, a summary of my rights under the FCRA. I further understand that I may request disclosure of the nature and scope of investigation, to the extent that such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living.

Signature of Applicant	Date
Printed Name Address	City State Zip
Date of Birth	Social Security Number
Driver's License Number and	State Name on Driver's License
Gender	Race

MEDICAL CERTIFICATION
FOR
SUPERVISED RESIDENTIAL HOUSING

FOR A PERSON THAT **DOES NOT** REQUIRE SKILLED NURSING SERVICES

FOR A PERSON **WHO IS CAPABLE** OF SELF- EVACUATION TO AN EXIT AND PUBLIC WAY OUTSIDE OF THE BUILDING, BEING MOBILE UNDER HIS OR HER OWN POWER WITH OR WITHOUT ASSISTIVE DEVICES, **WITHOUT** THE PHYSICAL ASSISTANCE OF STAFF OR OTHERS

THIS MEDICAL CERTIFICATION IS TO CERTIFY THAT:

_____

RESIDENT NAME

WAS EXAMINED BY ME AND FOUND TO BE **FREE FROM EVIDENCE OF COMMUNICABLE DISEASES** AND **NOT IN NEED OF NURSING CARE**.

THIS PERSON IS **CAPABLE OF SELF- EVACUATION** TO AN EXIT AND PUBLIC WAY OUTSIDE OF THE BUILDING, BEING MOBILE UNDER HIS OR HER OWN POWER WITH OR WITHOUT ASSISTIVE DEVICES, **WITHOUT** PHYSICAL ASSISTANCE FROM STAFF OR OTHERS.

THIS PERSON DOES NOT REQUIRE SERVICES THAT EXCEEDS THE LEVEL OF CARE PROVIDED BY THE STATE REGULATED SUPERVISED RESIDENTIAL HOUSING FACILITY.

THIS PERSON IS CAPABLE OF SELF-ADMINISTERING THEIR OWN MEDICATION WITHOUT SUPERVISION.

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Physician's or authorized Signature * **Date**

License or DEA #

DCA Revised 5/16/11

- **Signature must include at least the first initial and full surname and title (for example MD or RN.)**
- **of a person, not a group or hospital, legibly written with his or her own hand.**
- **LICENSE NUMBER ISSUED BY STATE OF NEW JERSEY MUST BE INCLUDED**

INITIAL CERTIFICATION MUST BE COMPLETED PRIOR TO ADMISSION, SUBSEQUENT CERTIFICATIONS YEARLY

A PERSON MUST BE LEGALLY AUTHORIZED TO ISSUE THIS CERTIFICATION, LICENSED BY THE STATE OF NEW JERSEY AS A PHYSICIAN OR AS A LICENSED ADVANCED NURSE PRACTITIONER OR AS A LICENSED CLINICAL NURSE SPECIALIST OR A LICENSED PHYSICIAN ASSISTANT

DISABILITY VERIFICATION FORM FOR SECTION 202/8 PROPERTIES

Name of Medical Professional: _____

Address: _____

PLEASE RETURN FORM TO:

Susan Kuzma, Supervisor
124 Bentley Avenue
Old Bridge, New Jersey
08857

SUBJECT: Verification of Information Supplied by an Applicant/Tenant for Housing Assistance

NAME: _____

ADDRESS: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown below.

Area to be completed by a Medical Professional

For each numbered item below, mark an "X" in the applicable box that accurately describes the person listed above.

1. _____YES _____NO — Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

2. _____YES _____NO — Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), i.e., a person with a severe chronic disability that:
   - a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   - b. Is manifested before the person attains age 22;
   - c. Is likely to continue indefinitely;
   - d. Results in substantial functional limitation in three or more of the following areas of major life activity:
     - (1) Self-care,
     - (2) Receptive and expressive language,
     - (3) Learning,
     - (4) Mobility,
     - (5) Self-direction,
     - (6) Capacity for independent living, and
     - (7) Economic self-sufficiency; and
   - e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

3. _____YES _____NO — Is a person with a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

4. _____YES _____NO — Is a person whose sole impairment is alcoholism or drug addiction.

Name and Title of Person Supplying the Information | Firm/Organization Name | Signature | Date

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would required the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature | Date

NOTE TO APPLICANT/TENANT: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208(a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 U.S.C. 408 (a) (6), (7) and (8).

Please return the form to the address listed above. Thank You.

EXPLANATION TO THE APPLICANT

REQUIRED TO BE GIVEN TO EACH APPLICANT BEFORE SIGNING THE VERIFICATION FORM.

HUD permits owners to verify that you have a disability only if:

1) Your eligibility for admission is dependent on your being a person with a disability; or

2) You claim eligibility for deductions that are given to a person with a disability.

The definitions of disability vary depending on the project you are applying for or living in. The owner determines the definition(s) to use by consulting with HUD Handbook 4350.3. The third party from whom this verification is being requested has knowledge of whether your disability meets the applicable definition(s) of disability (or person with a disability). An owner may request from a third party only the minimum information necessary to determine whether you meet the applicable definition of disability (or person with a disability). Any other request for information about you is not relevant and may not be asked (e.g., diagnosis, treatment plan).

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

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**