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 residency

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

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

Thank you for your interest in Community House at St. Thomas. Your assistance in reviewing this information and answering all questions helps us make Community House the best living experience possible for all.

Thank you,

Susan A. Kuzma, Case Manager
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 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 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

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INITIAL INFORMATION AND REQUEST FOR APPLICATION FOR RESIDENCY

A. NAME: _____ SOCIAL SECURITY# _____

ADDRESS: _____ BIRTHDATE/AGE: _____/____

_____ TELEPHONES: _____

_____ _____WORK

COUNTY: _____ _____E-MAIL

B. 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

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

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. ADDITIONAL COMMENTS/ACCOMMODATIONS NEEDED:

_____

_____

_____

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

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APPLICATION FOR RESIDENCY AT COMMUNITY HOUSE

NAME: _____

ADDRESS: _____

_____

PHONE: _____

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

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?

Catholic Charities
DIOCESE OF METUCHEN

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

United Way

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.

To complete the application process, an in person interview will be made at a mutually convenient time.

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

- Medical form from your physician.
- Medical form from your physical/occupational therapist (if you are in therapy.).
- Reference from your current case manager or personal assistance provider.
- 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 interview.**

1. Your personal assistance plan to obtain the services you need.
2. Proof of income and assets 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.
4.

Please submit this application by_____ to:

Susan A. Kuzma, case manager
Community House at St. Thomas
124 Bentley Ave.
Old Bridge, NJ 0885

Signature: _____

Date: _____

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. 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.

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

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

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 CASE MANAGER 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.

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._____
  _____
- HOW DOES PROGNOSIS IMPACT THE APPLICANT'S ABILITY TO RESIDE IN A SHARED LIVING ENVIRONMENT
  _____
  _____
  _____

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 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 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.

_____ _____

Applicant 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. In consideration 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 (Optional)
_____	_____
Driver's License Number and State	Name on Driver's License

State of New Jersey

Department of Community Affairs
101 South Broad Street
PO Box 804
Trenton, NJ 08625-0204

Division of Codes and Standards
(609) 633-6251 Bureau of Rooming and Boarding House Standards (609) 341-3187 – FAX

MEDICAL CERTFICATION

This Medical Certification is to certify that _____ was examined and found to be free from evidence of communicable disease and not in need of nursing care, capable of self evacuation with or without assistive devices and requires no services that are not available in a Boarding Home.

_____ _____

Date Physician's Signature*

* This form may be completed by a licensed nurse practitioner or a licensed clinical nurse specialist legally authorized to issue such certification.