



Ohio Multi-County Development Corporation

Please print ALL sections ink. DO NOT leave any sections blank, even those which do not apply to you. If a section does not apply to you, enter "none", or "N/A" (not applicable). Please answer the following questions truthfully, and to the best of your ability. Complete the application in full, otherwise it will NOT be considered for possible Housing Opportunities. Please return application to: **680 East Market, Akron, Ohio 44304 Suite 307 Phone. (330)315-3718 Fax: (330)374-5117**

PERSONAL

Full Legal Name _____ **Date of Application** _____

Social Security Number _____ **Date of Birth** _____ **Phone/Cell Number** _____

Referred by _____ **Phone #** _____

Emergency Contact _____ **Phone #** _____

Other Contact (family, etc.) _____ **Phone #** _____

Race: (optional - check all that apply)

- Asian
- American Indian or Alaska Native
- Black or African American
- White
- Native Hawaiian/Other Pacific Islander
- Other
- Other Multi-Racial

Are you a U.S. Military Veteran?

- Yes No

Do you have a long-term disability?

- Yes No

Please check Disabilities that apply to you:
(please check all that apply)

- Alcohol Abuse Drug Abuse
- Hearing Impaired Vision Impaired
- Developmental disability
- Physical or Medical Disability
- Other : _____

Gender:

- Male
- Female

Ethnicity: (optional - check one)

- Hispanic
- Non-Hispanic/Other

Are you currently homeless? Yes No

How many times in the past year have you been homeless? (check one)

- 1 or 2 times 3 or more times

Are you currently pregnant? Yes No

If yes, when are you due? _____

Are you HIV positive?

- Yes No

Please check Addictions that apply to you:
(please check all that apply)

- Alcohol Cocaine
- Crack Crystal
- Heroin Marijuana
- Methadone Prescription Drugs
- Sexual Addiction Tobacco
- Other:

Are you a Domestic Violence Victim?

- Yes No

If yes, how recent was the Domestic Violence?

- Within the last month 3 to 6 months ago
- 6 to 12 months ago More than a year ago

HOUSING INFORMATION

What is your current living situation?

- | | |
|--|--|
| <input type="checkbox"/> Foster care/Group Home | <input type="checkbox"/> On the Street |
| <input type="checkbox"/> Permanent Housing for Formerly Homeless | <input type="checkbox"/> Hospital* |
| <input type="checkbox"/> Nursing Home* | <input type="checkbox"/> Emergency Shelter* |
| <input type="checkbox"/> Own House/Apartment | <input type="checkbox"/> Living with Family |
| <input type="checkbox"/> Rental House/Apartment | <input type="checkbox"/> Living with Friends |
| <input type="checkbox"/> Jail, Prison or Juvenile Facility* | <input type="checkbox"/> Psychiatric Hospital or Facility* |
| <input type="checkbox"/> Transitional Housing for Homeless | <input type="checkbox"/> Substance Abuse Treatment Center* |
| <input type="checkbox"/> Hotel/Motel without emergency shelter | <input type="checkbox"/> Subsidized Housing |

*If facility, please list facility, contact person, and admission date:

How long have you been at your current address?

- | | |
|--|---|
| <input type="checkbox"/> One week or less | <input type="checkbox"/> More than one week but less than one month |
| <input type="checkbox"/> One to three months | <input type="checkbox"/> More than 3 months but less than one year |
| <input type="checkbox"/> One year or longer | |

Current Address:

Address	City	State	Zip
Landlord's Name	Phone		
Monthly Rent (\$)	Utilities (\$)		

Last Permanent Address:

Address	City	State	Zip
Landlord's Name	Phone		
Monthly Rent (\$)	Utilities (\$)		

Have you ever applied for a government-subsidized apartment before? Yes No

If Yes, when/where? _____

Do you have any outstanding fines and/or monies owed? Yes No



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EMPLOYMENT HISTORY

Are you currently employed?

Yes No.

If yes, how many hours did you work last week? _____

Are you looking for work? Yes No, Explain:

If employed what is your job status?

(check one)

Permanent Temporary Seasonal

Please list all full-time, part-time, self-employment, and/or seasonal employment:

Employer Name: _____

Address: _____

Phone#: _____ Annual Earnings (\$): _____

Earnings (\$) in the last 30 days? _____ The last 90 days? _____

Employer Name: _____

Address: _____

Phone#: _____ Annual Earnings (\$): _____

INCOME

What income do you currently receive? (please check all that apply and fill in all dollar amounts)

Income from other sources: Please place a check in the box next to all non-employment income you currently receive.

Source of Income:	(\$) Last 30 Days	\$ Last 90 Days	Claim/Acct.# (only if applicable)
<input type="checkbox"/> Alimony or Other Spousal Support			
<input type="checkbox"/> Child Support			
<input type="checkbox"/> Section 8, Public Housing or Rental Assistance			
<input type="checkbox"/> WIC – Special supplemental Nutrition Program			
<input type="checkbox"/> Food Stamps			
<input type="checkbox"/> General Assistance			
<input type="checkbox"/> Medicare			
<input type="checkbox"/> Medicaid			
<input type="checkbox"/> SCHIP			
<input type="checkbox"/> SSDI			
<input type="checkbox"/> SSI			
<input type="checkbox"/> Retirement Income from Social Security			
<input type="checkbox"/> TANF Child Care Services			
<input type="checkbox"/> TANF Transportation Services			
<input type="checkbox"/> Other TANF-Funded Services:			
<input type="checkbox"/> Unemployment Insurance			
<input type="checkbox"/> Veteran’s Pension			
<input type="checkbox"/> Veteran’s Disability Payment			
<input type="checkbox"/> Veteran’s Administration (VA) Medical Services			



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<input type="checkbox"/> Worker's Compensation			
<input type="checkbox"/> Pension from a past job			
<input type="checkbox"/> Private Disability Insurance			
<input type="checkbox"/> Employment			

MILITARY

What year did you serve in the Military? _____

How many months of active duty did you serve? _____

Did you serve in a War Zone?

Yes No

If yes, which one? _____

In which Military branch did you serve? _____

How were you discharged from the Military? _____

EDUCATION

Are you currently in school or working on a Degree? Yes No

If yes, name of school: _____

Have you received Vocational Training? Yes No

What is the highest level of Education you have completed:

- No schooling completed
- 10th grade
- Nursery school to 4th grade
- 11th grade
- Certification
- 5th or 6th grade
- 7th or 8th grade
- 9th grade
- 12th grade, no diploma
- High School Diploma
- GED
- Some Technical School
- Technical School
- Some College
- College Degree
- Graduate Degree

When/Where did you graduate High School? _____

Name degrees you have earned? _____



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CHILDREN

How many children do you have?

Please complete the following information for each child?

(use the back of this sheet if you need more room)

Name: _____ Age: _____ Permanent Custody? Yes No

In school? Yes No If yes, Type of school: _____

Enrollment problems: _____

Birth Date: _____ Social Security # _____

Name: _____ Age: _____ Permanent Custody? Yes No

In school? Yes No If yes, Type of school: _____

Enrollment problems: _____

Birth Date: _____ Social Security # _____

Name: _____ Age: _____ Permanent Custody? Yes No

In school? Yes No If yes, Type of school: _____

Enrollment problems: _____

Birth Date: _____ Social Security # _____

Name: _____ Age: _____ Permanent Custody? Yes No

In school? Yes No If yes, Type of school: _____

Enrollment problems: _____

Birth Date: _____ Social Security # _____

If you do not have permanent custody, what is the current arrangement?
(Please explain)



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BIO INFORMATION

Please answer the following questions as thoroughly as possible.

What is your marital status? (check one)

- Single Married Separated
- Widowed Divorced – please supply document

Do you currently use any illegal drugs or other illegal controlled substance?

- Yes No

If yes, please describe: _____

What was your prior use?

What is your documented sobriety date? (Please provide proof)

Do you see other outside professionals? (Please list all that apply)

Do you have a counselor? Yes

No

If yes, please give name and facility:

Counselor Name

Facility

Are you currently a client of CHC? Yes

No

If yes, who is your counselor?

Counselor Name

Have you ever been a client of CHC? Yes

No

If yes, when?

How did you hear about the CHC/ OMCDC Housing Programs?

What is your current diagnosis? (Please provide proof)

Are you on any medications? Yes

No

If yes, please list medications:



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Please list any past criminal activity including ALL misdemeanors and felonies. This will not disqualify you from our housing projects. (A background check will be conducted.)

Have you ever engaged in drug-related activity, such as use, possession, distributions, trafficking, or manufacture of an illegal drug? (A background check will be conducted.)

Yes No

If yes please explain:



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Please read the following CAREFULLY. Sign and date below:

The information provided on the previous pages is accurate and truthful to the best of my knowledge. I am aware that this is NOT a promise of placement, it is an application ONLY. I understand that a background check will be issued on my criminal history (if any). I understand that placing false information anywhere on this form may lead to disqualification of placement in the Community Health Center Program. I also understand that placing false information on this form is grounds for eviction should I be considered for placement in the Community Health Center Program. In the event that I am chosen for placement, I will be prepared to submit the following: security deposit, first month's rent, and any necessary documentation listed above (documented sobriety, diagnosis, and proof of income) at the time of lease signing.

ALL HOUSING APPLICATIONS MUST BE COMPLETED IN FULL, OTHERWISE THE APPLICATION WILL NOT BE CONSIDERED FOR HOUSING OPPORTUNITIES. PLEASE COMPLETE APPLICATION IN FULL. (FILL IN ALL SPACES, COMPLETE ALL QUESTIONS)

Signature _____ Date _____

Witness _____ Date _____

Driver's License Number _____



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CLIENT LOCATOR FORM:

Full Name of Adult: _____

Name To Be Called By: _____

Address: _____

Telephone Number: _____

Today's Date: _____

Name and address of Parent or Close Relative who does NOT live with you
Name:
Address:
City, State, Zip:
Phone:

Name and address of Parent or Close Relative who does NOT live with you
Name:
Address:
City, State, Zip:
Phone:

Name and address of Parent or Close Relative who does NOT live with you
Name:
Address:
City, State, Zip:
Phone:

If there is anyone you do not want contacted, please list below:
Name:
Address:
City, State, Zip:
Phone:



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Client Bio-Sheet

(Please note: This form MUST be completed in order for the Housing Application to be processed.)

Name: _____

Diagnosis: _____

Medications: _____

Date of Birth: _____

Social Security Number: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Diagnosis: _____

Medications: _____

Employer Phone: _____

Physician (Name and Phone): _____

Other Provider (Name and Phone): _____

Sponsor (Name and phone number): _____

Counselor (Name and phone number): _____

**PLEASE KEEP THIS PORTION OF THE APPLICATION
FOR YOUR RECORDS!**

Once your application is completed in full and submitted to OMCDC (Ohio Multi-County Development Corporation) or the Community Health Center, you will be scheduled for a housing interview. Please bring to the interview with you the following items: (if applicable)

1. Photo Identification
2. Social Security Card
3. Proof of Income (paycheck stubs, SSI, SSD verification)
4. Reunification Plan and/or working Case Plan with CSB, or Juvenile Court documentation.
5. Name, Birth Date, and Social Security Numbers for all children (whether or not you have custody)
6. Documentation of Diagnosis (from Doctor, Psychiatrist)
7. List of Medications currently being taken
8. Documentation of divorce or separation
9. Documentation of completion of Recovery Program