Breakthrough House

Supporting Mental Health Recovery

HOUSING PROGRAM APPLICATION PACKET

Updated 9/25/2013

Breakthrough House
Supporting Mental Health Recovery

• Tel (785)232-6807 • Fax (785)232-0751

APPLICATION CHECKLIST

Name_____ Date_____

- ☐ Background Check Authorization Form
- ☐ Housing Application
- ☐ Income Statement
- ☐ Provider/Team Contacts
- ☐ Emergency Contact
- ☐ Evaluation for Admission form (if moving into a group home, must be signed by a Licensed Medical or Mental Health provider)
- ☐ Release of Information Signed

ADDITIONAL DOCUMENTS THAT MUST BE INCLUDED WITH THE APPLICATION SUBMISSION

- ☐ Current Medication List
- ☐ Formal Mental Health Diagnosis from a Doctor or Mental Health provider
- ☐ 2-3 current progress notes and a treatment/service plan

Communication with the Breakthrough House_____

_____

_____

Breakthrough House
Supporting Mental Health Recovery

AUTHORIZATION FOR RELEASE OF BACKGROUND INFORMATION

PRINT CLEARLY

Identifying Code: 902KS3113

I hereby request and authorize the Kansas Bureau of Investigation and Intellisearch to furnish the above named company with criminal history information as described in K.S.A. 1985 Supp.22-470 (b). This includes all information defined with K.A.R.10-1-4 (b), (c), and (d).

I voluntarily waive all right of recourse and release you from liability for compliance with this authorization.

Full name: _____

Alias or Other Names Used: _____

Current Address: _____

List **City and State(s)** You Have Lived In the Past (5) Five Years Other Than Kansas _____

_____

Sex: _____ Race: _____ Birth Date: _____

Social Security Number: _____

Signature _____ Date _____

KBI Response:

_____

_____

Updated: 09/09/2016

Breakthrough Housing Rental Application

To be completed by office staff:

Date Application Rec'd_____
Time Application Rec'd _____
Signature of Staff member receiving application _____

Please print or type:

Full Name: _____

Current Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Household Member Information (List all household members who will be living in the unit at least 50% of the time.)

Member's Name	Relationship to Head	Date of Birth	Age	Social Security Number (SSN) *
	HEAD			

*Applicants do not need to disclose or provide verification of a SSN for household members to be placed on the waiting list. However, prior to admission, all applicant and tenant household members must disclose and provide verification of the complete and accurate SSN assigned to them except for those individuals who do not contend eligible immigration status or tenants who were age 62 or older as of January 31, 2010, and whose initial determination of eligibility was begun before January 31, 2010.

Residential History ***(Indicate the number of years' worth of rental history or number of previous landlords required according to the company policy or the tenant selection plan)***

1. Present Landlord/Property Name: _____
   Present address: _____ Apt. # _____
   City, State, Zip: _____
   Landlord Day Phone: (_____)_____ Rent Amt: $_____ per month
   Dates Rented/From: _____ To: _____

2. Previous Landlord/Property Name: _____
   Previous address: _____ Apt. # _____
   City, State, Zip: _____
   Landlord Day Phone: (_____)_____ Rent Amt: $_____ per month
   Dates Rented/From: _____ To: _____

3. Previous Landlord/Property Name:
4. _____
   Previous address: _____ Apt. # _____
   City, State, Zip: _____
   Landlord Day Phone: (_____)_____ Rent Amt: $_____ per month
   Dates Rented/From: _____ To: _____

If you are applying for a HUD PROPERTY then you will need to complete the (7) pages following. If you are applying for a Non-HUD property, you will only need to complete the application page.

General Questionnaire

1. Have you or any members of your household ever been evicted from a rental property? ☐ Yes ☐ No
   If yes, Property/Landlord Name:_____ City/State: _____

2. Are you or any members of your household currently receiving assistance from HUD? ☐ Yes ☐ No
   If yes, Property/Landlord Name:_____ City/State: _____

3. Have you ever been convicted of a criminal offense? ☐ Yes ☐ No
   If yes, Offense: _____ City/State: _____

4. Have you or any members of your household been evicted in the last three years from federally assisted housing for drug-related criminal activity? ☐ Yes ☐ No
   If yes, Property/Landlord Name:_____ City/State: _____

5. Are you or any members of your household currently using an illegal substance or drug? ☐ Yes ☐ No

6. Are you or any members of your household subject to the State lifetime sexual offenders registration? ☐ Yes ☐ No If yes, list the State where the offence occurred:_____

7. HUD requires criminal history background checks be completed in every state in which any household member has resided. List **all** the States in which any household member has ever resided:
   _____

8. Are you or any members of your household a U.S. Citizen or national of the United States?☐ Yes ☐ No

9. Are you or any members of your household a noncitizen with eligible immigration status? ☐ Yes ☐ No
   If yes, list the names of the household members who are a noncitizen with eligible Immigration status: _____

10. Will the apartment for which you are applying be the family's only residence? ☐ Yes ☐ No

11. Do you or any members of your household need an accessible unit? ☐ Yes ☐ No

12. How did you hear about our apartment community? _____

ADDITIONAL HOUSEHOLD INFORMATION	YES	NO
Are any members of the household absent from the home due to: Employment, Military Service, and Placement in foster care, Temporarily or Permanently confined to a nursing home or hospital, Away at school, or any other reason? If yes, please explain:		
Do you expect any changes to the number of household members in the next 12 months? If yes, please explain:		
Are there any Live-in Attendants in the household? (Live-in Attendants will be subject to the criminal/sex offender screening outlined in the Tenant Selection Plan)		
Are any members of the household enrolled as a student at an institution of higher education as defined under Section 102 of the Higher Education Act of 1965?		

INCOME - **List all income sources and monthly income amount:**

Are you or any other members of the household currently receiving income from any of the following sources?	YES	NO	MONTHLY INCOME
Wages, salaries (includes overtime, tips, bonuses, or commissions) If yes, list name(s) and address(es) of employer(s):			
Does any member of the household work for someone who pays them in cash? If yes, list name(s) and address(es) of employer(s):			
Wages earned through a government program such as Workforce Investment Act (formerly the Job Training Partnership Act) or Senior Aides, Older American Community Service Employment Program, AmeriCorps: If yes, which program:			
Income from the operation of a business If yes, provide a copy of most recent income tax return.			
Scholarships, Educational Grants, Work Study If yes, list the name and address of the college:			
Social Security Benefits If yes, list the name of the household member receiving the benefit and the claim number for the benefit:			
Disability/SSI Benefits If yes, list the name of the household member receiving the benefit and the claim number for the benefit:			
Death Benefits If yes, list the name and address of the agency paying the benefit:			
Pensions/Retirement Funds If yes, list the name and address of the agency paying the benefit:			
Periodic payments from IRA/Keogh/Any other Retirement accounts If yes, list the name and address of the financial institution:			
Annuities or non-revocable trust If yes, list the name and address of the financial institution:			
Unemployment Compensation or Severance Pay If yes, list the name and address of the agency paying the benefit:			

INCOME - List all income sources and monthly income amount: (cont.)

Are you or any other members of the household currently receiving income from any of the following sources?	YES	NO	MONTHLY INCOME
Military Pay If yes, list the name and address of the agency paying the benefit:			
Workman's Compensation If yes, list the name and address of the agency paying the benefit:			
Public Assistance/TANF/Cash Assistance If yes, list the name and address of the agency paying the benefit:			
Do you have a court order for Alimony or are you receiving Alimony payments? If yes, list the name and address of the agency paying the benefit:			
Do you have a court order for Child Support or are you receiving child support payments? If yes, list the name and address of the agency paying the benefit:			
Income from rent or sale of property If yes, provide a copy of most recent income tax return.			
Periodic payments other sources, such as lottery winnings If yes, list the name and address of the agency paying the benefit:			
Regular recurring contributions or gifts from organizations or persons not living in the unit, these sources may include rent and utility payments or other expenses, or cash If yes, list the name and address of the individual or agency paying the benefit:			
Insurance Policies If yes, list the name and address of the agency paying the benefit:			
Are there any adult members of the household (18 years of age or older) receiving income not listed above? If yes, list the source of the income:			
Are there any adult members of the household (18 years of age or older) claiming zero income or no income from the sources listed above? If yes, list the name of the household member:			
Did you or any other members of the household file a federal tax return last year?			

ASSETS - List all asset sources and the value of the asset:

Do you or any other members of the household have money in any of the following assets?	YES	NO	VALUE OF THE ASSET
Checking Account If yes, list the bank or financial institution:			
Savings Account If yes, list the bank or financial institution:			
Certificate of Deposit (CD) If yes, list the bank or financial institution:			
Money Market Funds If yes, list the bank or financial institution:			
Stocks/Bonds/Treasury Bills If yes, list the bank or financial institution:			
Annuities If yes, list the bank or financial institution:			
Access to a revocable Trust Funds If yes, list the bank or financial institution:			
IRA/Keogh Account/Any other Retirement accounts If yes, list the bank or financial institution:			
Real Estate (Includes homes and farmland) If yes, list the county in which the real estate is located and the address of the property: If you own Real Estate, is the real estate for sale or for rent?			
Own any Royalties or Mineral Rights If yes, list organization that can verify the income:			
Whole Life or Universal Life Insurance Policy (This does not include term life insurance policies which have no cash value) If yes, list the insurance agency:			
Cash held in a safety deposit box **or** in your home			
Assets held in another state or foreign country			
Do you or any other members of the household have any assets not listed above? If yes, list the asset and the bank or financial institution:			
Is money received from any of the assets or income sources listed above being deposited onto a pre-paid debit card? (such as: Direct Express, ReliaCard, NetSpend, Citi Bank, Etc.) If yes, list the card type and provide verification documentation:			

ASSETS - List all asset sources and the value of the asset: (cont.)

	YES	NO	VALUE OF THE ASSET
Have you or any other household members disposed of (or given away) any asset(s) for less than fair market value in the past two (2) years? If yes, list them here:			
Are any of the assets listed above held jointly with another person? If yes, list the asset and who it is held with:			

ASSETS – Lump Sum Payments (not received in periodic payments)

Have you or any other members of the household received any lump sum payments, such as:	YES	NO	AMOUNT OF PAYMENT
Inheritances			
Lottery winnings			
Insurance settlements for health, accident, Workers Compensation, etc.			
Capital gains			
Social Security benefits, unemployment compensation, etc.			
Other (specify):			

DEDUCTIONS

HUD Regulations allow for certain deductions that may be subtracted from annual income based on allowable family expenses and family characteristics. Please answer the following questions to see if you qualify for any deductions.	YES	NO
Are there any family members under the age of 18 in the household? If yes, list their name(s) here:		
Are there any family members who are a person with disabilities in the household? If yes, list their name(s) here:		
Are there any fulltime students 18 years of age or older in the household? If yes, list their name(s) here:		
Are there any household members who are elderly (age 62 or older)? If yes, list their name(s) here:		

DEDUCTIONS

HUD Regulations allow for certain deductions that may be subtracted from annual income based on allowable family expenses and family characteristics. Please answer the following questions to see if you qualify for any deductions.	YES	NO
Do you have medical expenses that are not paid for by an outside source such as insurance? (i.e. Services for doctors, health care professional, health care facilities, medical insurance premiums, prescriptions, dental expenses, eyeglasses, hearing aids and batteries) If yes, list the provider's name and address: (use additional paper if necessary)		
Do you pay child care expenses for a child (or children) under the age of 13 because you (check one box only) □ work □ are actively looking for work □ attend school? If yes, list the provider's name and address:		
Is any part of the child care expense paid by another person or agency? If yes, list the name and address of the agency paying:		
Do you pay for a care attendant or any equipment for a disabled household member necessary to enable that person or someone else in the household to work? If yes, enter the provider's name and address:		

FALSE OR INCOMPLETE INFORMATION WILL BE GROUNDS FOR DENIAL OF THE APPLICATION

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).

This application must be signed by all adults who will occupy the apartment before it can be considered. In compliance with the FAIR CREDIT REPORTING ACT this notice is to inform you that the processing of this application includes but is not limited to making any inquiries deemed necessary to verify the accuracy of the information herein, including procuring consumer credit reporting agencies and obtaining credit information from other credit institutions. Additionally, I authorize all corporations, companies, landlords, law enforcement agencies, academic institutions, and current employers to release information they may have about me and release them from any liability and responsibility from doing so.

Head of Household	Date	Co-head of Household	Date
Household Member	Date	Household Member	Date

This project does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities. As required in the HUD Occupancy Handbook 4350.3 REV-1, all individuals with disabilities have the right to request reasonable accommodations. Reasonable accommodations are changes, exceptions, or adjustments to a program, service, building, dwelling unit, or workplace that will allow a qualified person with a disability to: participate fully in a program; take advantage of a service; live in a dwelling; or perform a job. To show that a requested accommodation may be necessary, there must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability. Requests for Reasonable Accommodations should be brought to the attention of management.

Violence Against Women Act (VAWA) 2013 Notification Requirement: VAWA 2013 provides the following protections relating to admission, occupancy, and termination of assistance policies. Being a victim of domestic violence, dating violence, or stalking, as these terms are defined in the law, is not basis for denial of assistance or admission to assisted housing if the applicant otherwise qualifies for assistance or admission.

Breakthrough House
Supporting Mental Health Recovery

Provider Information

_____(Requires Documentation)

Mental Health Diagnosis

SUPPORT TEAM CONTACT INFORMATION

Psychiatrist	Location, Phone Number
Therapist	Location, Phone Number
General Physician	Location, Phone Number
Case Manager	Location, Phone Number
Social Worker	Location, Phone Number
Legal Representative	Location, Phone Number
Payee Representative	Location, Phone Number

Breakthrough House
Supporting Mental Health Recovery

EMERGENCY CONTACT

Name	Relationship
Address	City, State Zip code
Telephone Number	Email Address

Applicants Signature_____

Other Signature:_____

Date: _____

Comments:

Evaluation for Admission to a Residential Care Facility (RCF) Form

Name of Consumer: _____ Date: _____

To be completed by a Licensed Provider as defined by KSA 12-736

Licensed Provider conducting the evaluation and credentials: _____

Person has a history of fire setting (explain) _____

_____

_____

_____

Person has a history of violence or abuse (explain) _____

_____

_____

_____

Other situation or circumstance that could be assessed that the individual is a danger to others (specify) _____

_____

_____

_____

☐ Individual has been assessed as a danger to others and is not recommended for group home Placement.
☐ Individual is not a danger to others.

_____ Is suitable for group home placement because they are not assessed to be a danger to others

_____
Signature of Licensed Provider

To be completed by the Residential Care Facility Operator Designee

Name of Residential Care Facility or Group Home _____
Name of Owner/Operator completing Form _____

Individual referred to the RCF by:

☐ Hospital (name)
☐ VA
☐ Adult Protective Services
☐ Community Mental Health Center (specify)
☐ Relative or Guardian (specify)
☐ Other (specify)

☐ Individual is not involved with community corrections or diversion, on parole, or in a state psychiatric hospital finding an exclusion from criminal responsibility.

Client Signature _____ RCF or Group Home Designee _____

Breakthrough House, Inc. Authorization for Release of Information

Phone: (785) 232-6807

Name: _____ *DOB* _____ *SSN #* _____

I, _____ *hereby authorize:* _____
(Individual Authorizing Release) *(Agency)*

_____
(Address, City, State, ZIP, Phone Number)

☒ Disclose Information To ☒ Exchange Information with:

BREAKTHROUGH HOUSE, INC, Topeka, KS 66604

for the purpose of further treatment and planning.

This authorization acts as a ***dual release*** for both ***releasing information*** *and* ***obtaining information to:***

The information to be disclosed is:

☐ Treatment Plan ☐ Strength's Assessment ☐ Treatment Plan ☐ Medication Sheet
☐ Progress Note s (2-3 most recent) ☐ Finances

I Further, I authorize verbal communication in order to coordinate treatment/housing, allow discussion of treatment/housing progress, and discuss relevant concerns or issues regarding treatment/housing as well as to determine eligibility for housing.

The purpose of this disclosure is for: ☒ MENTAL HEALTH SUPPORTED HOUSING SERVICES AND PLANNING

I do hereby give this consent to the release of the records described above freely and voluntarily, and acknowledge that I am not under any force or duress.

I understand that the policy of Breakthrough House, Inc. is to promote the well-being of the individual. Breakthrough House, Inc. will release only that information about a client or a former client which, in the judgment of staff, is considered essential. The authorization does not obligate Breakthrough House, Inc. to open its records for inspection.

This consent shall remain effective for 12 months from the day of signing, UNLESS REVOKED IN WRITING.

Signed this _____ *day of* _____, _____.

_____ _____
Signature of Client *Signature of Guardian, or Authorized Representative*

_____ _____
Present Address *Nature of Relationship*

_____ _____
City, State, ZIP *Present Address*

_____ _____
Witness Signature *City, State, ZIP*

See Confidentiality Statement on Back

THE PURPOSE OF NEED FOR THE DISCLOSURE (Initial all that apply)

_____Evaluation / Treatment Planning ___x___ Housing Coordination _____Legal Proceedings
_____Screening/Acceptance in Program ___x_____ Other Housing Care and Planning

- I understand that under state and federal confidentiality provisions only the information specified can be released to only the specified person or agency. (CFR-42, part 2, KAR 30-60-47(b)(5), AAPS guidelines, Chapter 7)
- I also understand that Breakthrough House Inc. cannot assure that the recipient will maintain confidentiality of this information you have authorized to be released.
- I also understand that this authorization will be honored unless revoked in writing, or upon expiration as noted below. Revocation may be made at any time except to the extent that action has already been taken. To revoke, I must complete the Revocation of Authorization Form or correspond including all elements of the Revocation of Authorization Form and forward to Breakthrough Housing, 603 SW Topeka Blvd., Suite 100, Topeka, KS 66603. (KAR 30-60-47(b)(7), AAPS Standards for Lic/Certification Chapter 7, 1.a.(7), and CFR-42, part 2).
- I also understand that this release will expire: _____ (KAR 30-60-47(b)(6), CFR-42, part 2)
  (Not to exceed one year from signature date)

- I also understand that this authorization is voluntary. I understand that if the person or organization authorized to receive this information is not a health care provider or a health plan or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain person or organization may not re-disclose substance abuse treatment information. (CFR 42, part 2)

- I understand that information relating to HIV testing, HIV status or AIDS is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I verify that I have asked and received answers to all my questions.

_____ _____

Signature of Client Date

_____ _____

Signature of Authorized Representative/ Legal Guardian (if necessary) Date

_____ _____

Signature of Witness Date

INFORMATION RELEASED:_____

DATE INFORMATION RELEASED_____ BY WHOM:_____

Check One: ☐ By Phone ☐ By Mail ☐ In Person ☐ Electronic ☐ Fax ☐ Other

Prohibition on redisclosure: this information has been disclosed to you from records protected by federal confidentiality rules 42 CRF Part 2. The federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.