



Dear Applicant:

Thank you for your interest in applying for housing at New Beginnings. Our agency provides housing and supportive services to individuals with serious mental illness in Fayette County.

Attached to this letter you will find (1) Preliminary Application, (2) Authorization for Release of Information, and (3) Kentucky Determination Criteria Checklist for Serious Mental Illness (SMI). Please complete the pre-application and release forms and take the SMI checklist to someone who can verify your disability (therapist, psychiatrist, etc.). Once you have all 3 forms completed, you will need to return them to our main office at 225 Walton Avenue, Suite 120, Lexington, KY 40502.

We will review your information and if you appear to meet the eligibility requirement for our program, we will notify you that your name has been added to our waiting list. Please note that our waiting list can be very long so it is extremely important for you to keep us informed of your current telephone number and address. We will periodically send a letter to your last known address to see if you still wish to remain on our waiting list. If we do not hear back from you, we will remove your name from our waiting list.

When your name reaches the top of the waiting list we will contact you to complete a full application packet. A final decision regarding your eligibility cannot be made until the entire application has been received, verified, and reviewed. Once you have passed our final application and screening requirements, and an apartment is available that meets your needs, you will be notified to start the move-in process.

Should you have any questions or concerns please give me a call at the phone number above. All interested individuals have the right to complete and submit an application. We accommodate persons with disabilities who, as a result of their disabilities, cannot read or understand our application documents by providing alternative methods of accepting applications. Please let us know if you need an accommodation.

If you have any questions regarding completing the Pre-Application, please call us. We look forward to serving you.

Sincerely,  
Christy Shuffett, M.Ed.  
Executive Director



# PRELIMINARY APPLICATION FOR HOUSING

## NEW BEGINNINGS, BLUEGRASS, INC.

225 Walton Avenue, Suite 120, Lexington, KY 40502  
(859) 245-2400

### HEAD OF HOUSEHOLD INFORMATION

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Preferred Housing Type:  Supervised Living Program (staffed 24/7) or  Independent Housing

Does Head of Household have a serious mental illness?  Yes  No

Is Head of Household currently receiving behavioral health services?  Yes  No

### CONSENT TO RELEASE OR OBTAIN INFORMATION

I understand that to be eligible for housing and services at New Beginnings, Bluegrass, I must verify that I have a serious mental illness. I hereby give my permission to New Beginnings, Bluegrass staff to contact the following providers or facilities to verify my eligibility. I give these providers my permission to disclose information to New Beginnings, Bluegrass to verify my eligibility.

Name of Provider: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

### PRIORITY INFORMATION

You may qualify for a preference for housing assistance if any of the following circumstances can be verified for your family. Please check any that apply to you at this time.

- Are you currently residing in a hospital, personal care home, or treatment facility?  Yes  No
- Are you residing in a place not meant for sleeping such as a vehicle, an abandoned building, bus station, or anywhere outside?  Yes  No
- Are you living in an emergency shelter?  Yes  No
- Are you residing in a transitional housing program for homeless persons?  Yes  No
- Are you facing imminent risk of losing your primary nighttime residence?  Yes  No

**HOUSEHOLD COMPOSITION**

Please list all persons who will live with the Head of Household. Use additional pages if needed.

First Name	Last Name	Social Security Number	Date of Birth	Sex	Relationship to Head

**HOUSEHOLD INCOME**

Please list the source and amount of all current income received by family members, including Head of Household. Include all earnings and benefits received from employment, SSI, SSDI, unemployment, worker’s compensation, VA, child support, TANF, etc. Use additional pages if needed.

Family Member Name	Source of Income	Monthly Income Amount

**APPLICANT CERTIFICATION**

I understand that when my name reaches the top of the waiting list, I will be contacted by New Beginnings to complete the full application process. I also understand that this pre-application provides only preliminary information and that no final determination of eligibility will be made until the full application process is completed.

I certify that the information provided on this pre-application is true and accurate. I authorize New Beginnings to verify this information. I understand that false information will result in my application being cancelled or denied.

I understand that it is my responsibility to inform New Beginnings of any changes to my address or telephone number and understand that my application may be cancelled if I fail to do so.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Date

*It is the policy of New Beginnings, Bluegrass to promote nondiscrimination and ensure fair and equal housing opportunities for all. We are fully committed to promoting and engaging the participation of all people regardless of race, color, religion, sex, age, national or ethnic origin, familial status, disability, actual or perceived sexual orientation or gender identity. Persons with language barriers may request or arrange interpretation alternatives or services.*



**FOR OFFICE USE**

Date Received: \_\_\_\_\_

Time Received: \_\_\_\_\_

# Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD)  
and the Housing Agency/Authority (HA)

U.S. Department of Housing  
and Urban Development  
Office of Public and Indian Housing

OMB CONTROL NUMBER: 2501-0014

exp. 1/31/2014

PHA requesting release of information; **(Cross out space if none)**  
(Full address, name of contact person, and date)

IHA requesting release of information; **(Cross out space if none)**  
(Full address, name of contact person, and date)

**Authority:** Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

**Purpose:** In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

**Uses of Information to be Obtained:** HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

**Who Must Sign the Consent Form:** Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

**Failure to Sign Consent Form:** Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

### Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(I)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

**Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.**

This consent form expires 15 months after signed.

Signatures:

_____	_____		
Head of Household	Date		
_____		_____	_____
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
_____	_____	_____	_____
Spouse	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date
_____	_____	_____	_____
Other Family Member over age 18	Date	Other Family Member over age 18	Date

**Privacy Act Notice.** Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

**Penalties for Misusing this Consent:**

HUD, the HA and any owner (or any employee of HUD, the HA 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 the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully 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, the HA or the owner responsible for the unauthorized disclosure or improper use.

# Kentucky Determination Criteria Checklist for Serious Mental Illness (SMI)

*Relates to KRS 210.005 and 907 KAR 15:060, 15:065, 15:050, and 15:055*

Individual's Name \_\_\_\_\_

Identification Number \_\_\_\_\_

SMI Diagnostic Code(s) \_\_\_\_\_

The following table illustrates the criteria that shall be met for an individual to be designated as seriously mentally ill (SMI). In order to designate an individual as SMI, all of the criteria in Sections 1, 2, 3 and 4 shall be met.

Please check the following criteria for age, diagnoses, disability and duration.

YES	NO	CRITERIA																								
		<p><b>1. Age:</b> Is a person aged 18 years or over (calculated at the time of service)</p>																								
		<b>AND</b>																								
YES	NO	<p><b>2. Diagnosis</b> <i>(please circle applicable diagnosis)</i></p> <p>Has one or more of the following mental health diagnoses as designated in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders:</p> <p><b><i>Schizophrenia Spectrum and Other Psychotic Disorders</i></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Delusional Disorder</td> <td style="width: 20%;">297.1</td> </tr> <tr> <td>Schizophreniform Disorder</td> <td>295.40</td> </tr> <tr> <td>Schizophrenia</td> <td>295.90</td> </tr> <tr> <td>SchizoAffective Disorder</td> <td>295.70</td> </tr> <tr> <td>Other Specified Schizophrenia Spectrum and Other Psychotic Disorder</td> <td>298.8</td> </tr> <tr> <td>Unspecified Schizophrenia Spectrum and Other Psychotic Disorder</td> <td>298.9</td> </tr> </table> <p><b><i>Bipolar and Related Disorders</i></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Bipolar I Disorder</td> <td style="width: 20%;">296.41, 296.42, 296.43, 296.51, 296.52, 296.53, 296.44, 296.45, 296.46, 296.40, 296.54, 296.55, 296.50</td> </tr> <tr> <td>Bipolar II Disorder</td> <td>296.89</td> </tr> <tr> <td>Cyclothymic Disorder</td> <td>301.13</td> </tr> <tr> <td>Other Specified Bipolar and Related Disorder</td> <td>296.89</td> </tr> <tr> <td>Unspecified Bipolar and Related Disorder</td> <td>296.80</td> </tr> </table> <p><b><i>Depressive Disorders</i></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Major Depressive Disorder</td> <td style="width: 20%;">296.21, 296.31, 296.22, 296.32, 296.23, 296.33, 296.24, 296.34, 296.25, 296.35, 296.20, 296.30</td> </tr> </table>	Delusional Disorder	297.1	Schizophreniform Disorder	295.40	Schizophrenia	295.90	SchizoAffective Disorder	295.70	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	298.8	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	298.9	Bipolar I Disorder	296.41, 296.42, 296.43, 296.51, 296.52, 296.53, 296.44, 296.45, 296.46, 296.40, 296.54, 296.55, 296.50	Bipolar II Disorder	296.89	Cyclothymic Disorder	301.13	Other Specified Bipolar and Related Disorder	296.89	Unspecified Bipolar and Related Disorder	296.80	Major Depressive Disorder	296.21, 296.31, 296.22, 296.32, 296.23, 296.33, 296.24, 296.34, 296.25, 296.35, 296.20, 296.30
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		Persistent Depressive Disorder (Dysthymia)	300.4
		Other Specified Depressive Disorder	311
		Unspecified Depressive Disorder	311
		<b>Trauma and Stressor Related Disorders</b>	
		Posttraumatic Stress Disorder	309.81
		<b>AND</b>	
<b>YES</b>	<b>NO</b>	<b>3. Disability (Please circle domains with impairments)</b> Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> <li>• <b>Societal/Role Functioning:</b> Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.</li> <li>• <b>Interpersonal Functioning:</b> How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.</li> <li>• <b>Daily Living/Personal Care Functioning:</b> How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.</li> <li>• <b>Physical Functioning:</b> Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.</li> <li>• <b>Cognitive/Intellectual Functioning:</b> Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.</li> </ul>	
		<b>AND</b>	
<b>YES</b>	<b>NO</b>	<b>4. Duration (Please circle at least one duration condition)</b> One or more of these conditions of duration: <ul style="list-style-type: none"> <li>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least 2 (two) years.</li> <li>• The individual has been hospitalized for mental illness more than once in the past 2 (two) years.</li> <li>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time.</li> </ul>	

This individual meets the criteria for the designation of Serious Mental Illness (SMI). Documentation of the existence of these criteria of Age, Diagnosis, Disability and Duration is present in the individual's medical record and assessment has been conducted by a qualified, licensed behavioral health professional.

\_\_\_\_\_/\_\_\_\_\_  
Print Name and Credentials      Signature

\_\_\_\_\_  
Date