AIDB Talladega Regional Center
Deaf. Blind. Limitless.

Applicant Initials: ____
Disability: __________

Supportive Housing Program

SUPPORTIVE HOUSING PROGRAM APPLICATION

Persons who are interested in the Supportive Housing Program should contact the **Talladega Regional Center Social Work Department at 256-761-3370**. Individuals referred must submit background information for consideration by a referral committee.

Mark that the following items have been completed and are included as applicable:

___ General Information Page
  ___ Current Photo ID
  ___ Proof of Current Medical Insurance
___ Statement of Interests
___ Medical History
  ___ Questionnaire
  ___ Background
  ___ Doctors Documentation/Physical
    ___ Report from Audiologist, Optometrist, or Ophthalmologist
___ Mental and Emotional Health Background/Documentation
___ Financial Information
  ___ Proof of Income
  ___ Budget Worksheet
  ___ Proof of Checking/Savings Account
  ___ Auto Pay Form
___ Adjudication Information
  ___ Release of Information
___ Copy of Current Lease Agreement
___ 2 Letters of Reference (explanation of need)
___ Toured Union Village (in-person or virtual)

Explanation for any missing items: ______________________________
____

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GENERAL INFORMATION:

Date: ___________

Name: ____________________________ SS # __________________

Address: ____

Phone Number: ____

Source of Referral: _________________________________

Employer Name: _______________________________________

Employer Address: __________________________________

Employer Phone Number: ____________________________

Gender: ________ D.O.B ___/___/___ Age: ____ Race: _____

Deaf, Blind, Deaf Blind, or Other Disability: _________________

Emergency Contact Name: ____________________________

Address: ____

Phone Number: ____

INTERNAL USE ONLY:

Date Application Received: ___________

Date Application Received COMPLETED: ___________

Accepted: ___________

Denied: ___________

Comments: ____

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STATEMENT OF INTERESTS

Use the space below to provide a detailed explanation of why you are interested in participating in the Supportive Housing Program.

____

____

____

Select the services and/or areas of interest while participating in the Supportive Housing Program:

___ Assistive Technology

___ Personal/Work Adjustment

___ Advocacy

___ Case Management

___ Center-based ADL Classes

___ Braille Production for Consumers

___ Non-Clinical Counseling

___ Recreation

___ Support Groups

___ Consumer Education Workshops

___ Social Services

___ Transportation Services

___ American Sign Language (ASL) Classes

___ Interpreting Services

___ Video Relay Phone

Other Services/Interests:

____

Do you drive a vehicle? **YES** ___ **NO** ___

If yes, will you be bringing a vehicle with you to park on campus?

YES ___ **NO** ___

Make and Model of Vehicle: ____________________________________

Tag Number of Vehicle: ____

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PLEASE PROVIDE PROOF OF INSURANCE AND REGISTRATION

MEDICAL HISTORY QUESTIONNAIRE

Do you or have you ever had issues with:

YES	NO		YES	NO	
		Heart Problems			Cancer
		Blood Pressure			Bones/Joints
		Kidney/Bladder			Nerves/Anxiety
		Stroke			Head Injury
		Diabetes			Back Injury
		Asthma/Allergies			Frequent Headaches
		Seizures			Lungs/Tb
		HIV Infection			Venereal Disease

Explain fully each marked **YES**:

____

____

____

Have you seen a doctor the past three years? **YES**___ **NO** ___

If yes, explain:

____

____

____

Have you ever had an addiction to alcohol or drugs? **YES**___ **NO** ___

If yes, please explain:

____

____

____

Supportive Housing Program

Do you have any allergies to food or medication? **YES** ___ **NO** ___
If yes, please explain:

____

List current:

Medication	Dosage	Doctor

Do you administer and/or sort your own medication? **YES** ___ **NO** ___
If yes, how do you currently manage your medication (pill planners, injections, pumps, accessible labels, assistive devices, etc.):

____
____
____

Have you ever been hospitalized? **YES** ___ **NO** ___

Dates	Hospital	Reason

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MEDICAL HISTORY DOCUMENTATION

to be completed by applicant's primary physician or CNP

NAME: ______________________ AGE: _____ WT: _____ HT: _____

Please list current:

Medication	Dosage

Other than vision or hearing, does the patient have any physical conditions, which would prohibit activities of independent daily living?
YES ___ **NO** ___
If yes, please note any physical conditions or related limitations:
____
____
____

Does the patient have any communicable diseases that would be potentially harmful for other residents living in a group or communal style setting? **YES** ___ **NO** ___

I certify that the above information is true and correct to the best of my knowledge:

_____________________ _____________________ __________
Physician/CNP (Print) Signature Date

This form can be returned to
AIDB Talladega Regional Center via fax at 256-761-3693

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Physical Examination Form

Name: ___________________________ Date of Exam: ____________________

Address: ____

Date of Birth: ____________________ Sex: ☐ Male ☐ Female

Evaluation of Systems:

Does applicant have problems with:	Findings?		Comments?
	YES	NO	
MOBILITY			
DIABETES			
FALLING			
SEIZURES			
ASTHMA			
ALLERGIES			
MEDICATION MANAGEMENT			

Does the patient require adaptive equipment? **YES** ___ **NO** ___
If yes, what equipment: ____

Is there a change in health status from previous year(s)? **YES** ___ **NO** ___
If yes, please explain:

____
____
____

______________________ ______________________ ___________
Physician/CNP (Print) Signature Date

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MENTAL AND EMOTIONAL HEALTH INFORMATION

Have you seen a counselor/therapist/psychiatrist in the past three years? **YES** ___ **NO** ___ If yes, explain:

____
____
____

Have you ever been treated for emotional problems? **YES** ___ **NO** ___ If yes, please indicate name and address of doctor and date(s) of treatment:

____
____
____

If you have answered **yes** to **either** of the above questions, a letter or statement from the counselor/therapist/psychiatrist is **required**. The letter will need to include any diagnoses, medications, and a recommendation on whether or not the patient has ever presented any psychological, neurological, or psychiatric issues that would prohibit him/her from residing in a group or communal style setting with other residents. This letter or statement will need to be sent in with the rest of the supportive housing program application.

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BUDGET WORKSHEET

Provide detailed information about your current or most recent income and expenses.

INCOME

Income/Salary (Work) [Must provide proof of income]	
Other Income (SSDI, SSI, Child Support/Alimony, Retirement, Etc.) [Must provide proof of income]	
TOTAL INCOME	

EXPENSES

Rent	
Utilities	
Food	
Medicines	
Phone/Internet	
TOTAL EXPENSES	

Total Monthly Income	
Total Monthly Expenses	
NET CASH FLOW	

If you have no income or a negative net cash flow, please provide detailed information about your plans to pay your living expenses:

____

____

____

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Program

Bank Dr ay Form

Personal Information

Name: ___________________________________

Phone Number: ______________ Email: _________________________

Cottage:

- ☐ Warner Cottage (20 Ozark Circle)
  - Unit #: _____ $_____
- ☐ Mohns Cottage (30 Ozark Circle)
  - Unit #: _____ $_____
- ☐ Northington Cottage (25 Ozark Circle)
  - Unit #: ______ $_____
- ☐ Jordan Cottage (55 Ozark Circle)
  - Unit #: _____ $_____
- ☐ Gabbie Cottage (75 Ozark Circle)
  - Unit #: _____ $_____
- ☐ Tiny Home (65 Ozark Circle)
  - Unit #: _____ $_____

Mailing Address (if different from above):

____

Banking Information

Routing Number: _________________________

Account Number: ________________________

Name of Bank: ________________________

I authorize Presbyterian Home for Children (PHFC) to begin drafting my monthly fee amount on the 1st of each month. This amount will be the agreed fee amount as stated in my program service agreement. This authority will remain in effect until I notify PHFC in writing at least 5 business days prior to the draft date. I understand that either party may terminate this agreement at any time. Any payments charged back for not sufficient funds, closed account, etc. are subject to a service fee of $35.00 or the maximum allowed.

___________________________________ _______________

Authorizing Signature Date

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ADJUDICATION INFORMATION

Have you ever been convicted of a felony? **YES** ___ **NO** ___
If yes, please explain fully and include what state:

____
____
____
____
____

Do you currently have any pending arrests, court orders or parole conditions? **YES** ___ **NO** ___
If yes, please explain fully:

____
____
____
____
____

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Supportive Housing Program

Alabama Institute for Deaf and Blind

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Alabama Institute for Deaf and Blind to release/receive specified information from the record of: ____________________________ to ____________________________. This information shall include (nature and extent of information to be released):

____

____

____

I understand this information will be used for:

____

____

____

Other information: ____

I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until the end of my time with the supportive housing program. I understand that I may revoke this consent at any time except to the extent that information has already been released before I revoke it.

__________________________	__________________________
Consumer Signature	Consumer Representative Signature
__________________________	__________________________
Printed Name	Printed Name and Relationship
__________________________	__________________________
Date	Staff Name

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APPLICANT CERTIFICATION

I understand that this application is not an offer of participation in the Supportive Housing Program. I understand that the Alabama Institute for Deaf and Blind (AIDB) will make no more than one offer of participation to the Supportive Housing Program based on this application. If I do not accept that offer, my application will be removed from the waiting list; and, if I reapply, my application will not receive any priority or preference that was granted on the prior application. Based on this application, I understand I should not make plans to move or end my present tenancy until I have received a written notification of referral from AIDB. I understand that it is my responsibility to inform AIDB in writing of any change of address, income, or household composition. I authorize AIDB to make inquiries to verify the information I have provided in this application. I certify that the information I have given in this application is true and correct. I understand that any false misrepresentation may result in the denial of my application or in termination of agreement. I understand that AIDB will request a Criminal Background History Check for all adult members of the household. I understand that I hereby give an AIDB third-party representative permission to perform an evaluation of my current home to evaluate safety and accessibility.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY: I understand that a photocopy of this application and a photocopy of this signature as valid as the original.

Applicant's Signature: ________________________ Date: __________