



ICAN Affordable Housing Application

1214 Market Avenue North, Canton, Ohio 44714
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 Web: www.ican-inc.org Email: ican@ican-inc.org

I. APPLICANT INFORMATION

First Name	MI	Last Name		
Street Address or where you slept last night if homeless				
Social Security #		Male/Female	Birth date	Phone
Veteran Yes/No	Marital Status	Family Size	Adults/Children	Highest Grade Completed
Ethnicity of Head of Household: (for statistical purposes only)		Race of Head of Household: (for statistical purposes only)		
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Island <input type="checkbox"/> White		

II. HOUSING HISTORY

Has applicant applied for other permanent housing subsidy programs (if yes, please list below)

Criminal history within the last 3 years (please specify felony charges)	Sex Offender (if yes, what tier)
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III. VERIFICATION OF HOMELESSNESS

Describe manner in which client is homeless (shelter, streets, etc.)

If at imminent risk of homelessness, please list details below

HMIS #	Number of homeless episodes in the last 3 years)	Chronically Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IV. SUPPORT SERVICES

Agency Providing Support Services

Case Manager/Support Provider	Phone Number
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V. VERIFICATION OF DISABILITY

Has a mental health disability, as defined in 42 U.S.C. 423, which means; Inability to engage in substantial gainful activity by reason of any medically determinable mental impairment that has lasted or can be expected to last for continuous period of not less than 12 months

Yes No

Disability is combined with any drug or alcohol abuse

Yes No

Disability is based solely on any drug or alcohol dependence (the person has no other disability which meets the above definition)

Yes No

Applicant has a severe and persistent psychiatric illness

Yes No

Are there physical limitations that would affect this individuals housing? (if yes, explain)

TITLE AND SIGNATURE OF INDIVIDUAL VERIFYING DISABILITY (<u>must</u> be licensed to verify)	Date
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VI. FINANCIAL INFORMATION

Present Source of Income	Monthly Amount	\$
Current Employer	Dates	
	From	To
Over the last five years have you been employed for a year or more? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What benefits have you applied for? (check all that apply)		
<input type="checkbox"/> OWF <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> General Assistance (GA) <input type="checkbox"/> Medicaid/Medicare <input type="checkbox"/> Child Support <input type="checkbox"/> Unemployment <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other _____		
Do you have a payee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Payee	
Do you have outstanding utility balances? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever applied for PIPP/HEAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

VII. APPLICANT CERTIFICATION

Please initial each statement below:

I understand that this information is being collected to determine my preliminary eligibility for affordable housing _____
I authorize ICAN to verify/share all necessary information provided herewith the support provider and agency listed on this application _____
I certify the statements made in this application are true and complete to the best of my/our knowledge _____

Applicant Signature	Date
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VIII. SUPPORT PROVIDER VERIFICATION

Please supply any additional information below that you feel would be helpful to consider when determining preliminary eligibility for ICAN housing programs:

Signature of Support Provider	Date
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