



ICAN Housing Solutions
Where Hope and Independence Begin

Supportive Housing Voucher
Program Application

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ICAN, Inc., 1214 Market Avenue, North, Canton, Ohio 44714-2604
Phone: (330) 455-9100 Fax: (330) 455-4702 www.ican-inc.org

Supportive Housing Program Priorities Checklist

Name: _____

Date: _____

The Supportive Housing Program is to help participants who have serious mental illness become self-sustaining in permanent housing. The goal is for the participant to stabilize their mental health through continuing treatment and to pay their own rent within three years.

To determine if the program will enable you, the applicant, to become self reliant please complete the following questionnaire.

To help you consider your life priorities, we ask you to complete this exercise. Which of the following is most important (1) to you; which is least (10)?

Circle one number in each category that represents your interest in that area. You can choose only one 1 (most desirable) in the list, only one 2, only one 3, etc. You will end up with one number circled in each row and column.

CIRCLE ONE NUMBER IN EACH ROW AND ONLY ONE IN EACH COLUMN

Category Most important _____ → Least important

Employment:	1	2	3	4	5	6	7	8	9	10
Education:	1	2	3	4	5	6	7	8	9	10
Permanent Housing:	1	2	3	4	5	6	7	8	9	10
Sobriety:	1	2	3	4	5	6	7	8	9	10
Family Relationships:	1	2	3	4	5	6	7	8	9	10
Safety and security:	1	2	3	4	5	6	7	8	9	10
Increasing income:	1	2	3	4	5	6	7	8	9	10
Greater self determination	1	2	3	4	5	6	7	8	9	10
Mental health recovery:	1	2	3	4	5	6	7	8	9	10
Choose your own _____	1	2	3	4	5	6	7	8	9	10

What is one thing you want to do to increase your self determination?

Answer: _____



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OFFICIAL Homeless Certification

Participant Name: _____ HMIS No.: _____
Agency Providing Services: _____ Case Manager: _____

This statement serves as verification that the applicant listed above is homeless in the manner checked below:

Is sleeping in the following places not meant for human habitation (check one): Park Car Sidewalk

Abandoned building other (specify) _____

Is sleeping in _____ emergency shelter.

Is from _____ transitional housing or supportive housing for homeless persons; originally came from the street or emergency shelter.

In any of the places but is spending a short time (up to 30 consecutive days) in the hospital or institution. Name of institution: _____.

Please explain your attempts to identify other housing or a support network such as family or friends.

Is being evicted within 7 days from a private dwelling unit (LIST ADDRESS BEING EVICTED FROM HERE):

 No subsequent residence has been identified and the person lacks resources and support networks needed to obtain housing. **Explain:** _____

 Is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. **Explain:** _____

 Is being foreclosed upon within the week. **Explain:** _____

 Is being evicted by family or friend where there is no formal eviction. **Please attach letter from family or friend stating that the occupant has to vacate.**

Signature & Title of person verifying homelessness Date

Participant's Signature Date

PENALTIES FOR MUSUSING 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, the PHS and any owner (or any employee of HUD, the PHA) may be subject to penalties for unauthorized disclosure or improper use of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purpose cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretence concerning an application or participants may be subject to misdemeanor and not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action or damages, and seek other relief, as may be appropriate against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provision for misusing the social security number are contained in the Social Security ACT at 42 U.S.C. 208(f)(g) and (h). Violation of these provisions are cited as violation of 42 U.S.C 408 (f) (g) and (h).

Created by Stark County Homeless Services Collaborative
ICAN, Inc., 1214 Market Avenue, North, Canton, Ohio 44714-2604
Phone: (330) 455-9100 Fax: (330) 455-4702 www.ican-inc.org

Date _____

APPLICATION **Supportive Housing Voucher Program**

Referring Agency: _____

I. APPLICANT INFORMATION

Please check the size of unit for which you are applying (you may choose more than one):

Efficiency 1 bedroom 2 bedroom

Name	Application Number
------	--------------------

Address	City	State	Zip
---------	------	-------	-----

Phone Number	How long have you lived at this address?
--------------	--

Type of housing currently living in (own apartment / temporary shelter / living with friends / etc.)

Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status	Education
---	----------------	-----------

Race of Head of Household: (for statistical purposes only) <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	Ethnicity of Head of Household: (for statistical purposes only) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
--	---

II. HOUSEHOLD COMPOSITION AND CHARACTERISTICS

List the Head of Household and all other members who will be living in the unit. Give the relations of each family member to the head.

Participant Number	Participant Name	Relationship to Head of Household	Birthdate	Age	Sex	Social Security Number

Does anyone live with you now who is not listed above? yes no

Do you expect a change in your household composition? yes no

Explain if you answered yes to either question above:

Is head of household or spouse disabled? yes no (For program and unit eligibility purposes only)

Please identify any special housing needs your household has:

Do you or anyone in your household currently engage in or have you or anyone in your household have a history of engaging in the use of controlled substances?

yes no If yes, please specify:

Are you or anyone in your household subject to a state lifetime registration requirement for sex offenders?

yes no If yes, please identify household member:

Have you or anyone in your household ever been convicted of a crime?

yes no If yes, please identify household member:

III. HOUSING HISTORY

Have you ever been evicted? yes no If yes, please list reason(s):

Current or most recent landlord	Why did you move from this unit?
---------------------------------	----------------------------------

Address or phone number of current landlord:

Name and address or phone number of a former landlord:

How many times have you been homeless in the last three years?

IV. GENERAL INFORMATION

How did you hear about our housing program?

If you are accepted to receive assistance, please list a phone number, address, or contact person where you may be reached:

Have you been hospitalized for mental health reasons?

yes no If yes, please identify date(s) and place(s) of residential care:

V. FINANCIAL INFORMATION

Present source of income	Monthly amount \$
--------------------------	----------------------

List any and all income that you expect to receive during the next year:

If you do not currently have an income, have you applied for benefits? yes no

If yes, please list the type of benefits and date applied:

Health Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify):	Spenddown? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, amount: \$	Food Stamps <input type="checkbox"/> yes <input type="checkbox"/> no If yes, amount: \$
---	---	--

Do you have a payee? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, name and address:
--	---------------------------

Do you own a working car? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you a veteran? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you owe any utility balances? <input type="checkbox"/> yes <input type="checkbox"/> no
---	--	--

VI. APPLICANT CERTIFICATION

I/we certify that if selected to receive assistance, the unit I/we occupy will be my/our only residence. I/we understand that the above information is being collected to determine my/our eligibility. I/we authorize ICAN to verify all information provided on this application and to contact previous or current landlords or other sources of credit and verification information that may be released to appropriate federal, state, or local agencies. I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief. I/we understand that false statements or information are punishable under federal, state and/or local laws. I/we authorize ICAN, my case manager, and prospective landlord(s) to consult with each other and make necessary and reasonable interventions to preserve the safety, sanitation and permanence of my rent subsidy and/or housing situation.

Signature of Applicant _____ Date _____

VII. SUPPORT PROVIDER VERIFICATION

Please describe the type and frequency of support to be provided by agency/person making this referral:

Signature of Case Manager _____ Date _____

VIII. OWNER / MANAGER REPRESENTATIVE SIGNATURE

Signature of ICAN Staff _____ Date _____



ICAN Housing Solutions
Where Hope and Independence Begin

**GOALS YOU AGREE TO ACCOMPLISH TO PARTICIPATE IN
THE SHP VOUCHER PROGRAM**

Goal #1: Achieve residential stability

- Within 30 days of this application, locate an apartment with a rent not to exceed Fair Market Rent including utilities.
- Landlord to complete the Request for Tenancy Approval form.
- Apply to Stark Metropolitan Housing for permanent housing

Goal #2: Increase skill levels and/or income

- Apply for food stamps at ODJFS.
- Apply to a vocational or educational program to learn skills necessary to obtain employment

Goal #3: Obtain greater self-determination

- Identify and apply to one social service programs that can help you improve your network of support

CONTINUING: You agree to meet with the Supportive Housing Specialist at least every 90 days to document and update your Goals Plan. You must work toward these three goals categories to retain your rent subsidy.

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ICAN Housing Solutions
Where Hope and Independence Begin

Supportive Housing Program

RELEASE OF INFORMATION FORM

I, _____, authorize ICAN, Inc. to exchange information relating to the medical/mental health/ social services care for:

Name _____ Date of birth _____

Address _____

Telephone # _____ Soc. Sec. No. _____

The information may be exchanged with:

Provider Name _____ Telephone # _____

Address _____

For services provided between _____ and _____

Information that can be shared may include any professional communications about:

- | | | |
|---|---|--|
| <input type="checkbox"/> Need Assessment(s) | <input type="checkbox"/> Arrest/Conviction Record | <input type="checkbox"/> History of homelessness |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Drug/Alcohol History | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Mental Health Diagnosis Verification | | |

This Information is to be used for:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Housing | <input type="checkbox"/> Support Services | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Other (Specify) _____ | |

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ICAN Housing Solutions

Where Hope and Independence Begin

Please read the following before signing this authorization to exchange information:

1. Make sure that all blanks are filled in before signing.
2. You may inspect or copy any information used/disclosed/exchanged under this authorization.
3. You have the right to refuse the exchange of information about you (with 3 legal exceptions; when it is by court order, where a life may be in danger, or when child abuse is suspected).
4. You have the right to revoke this authorization in writing at any time by advising ICAN. This release is only valid for 90 days from the date of your signature for medical and/or mental health data. It is valid until revocation for social service data unless you state a specific end date.
5. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness, and/or alcohol/drug abuse/dependency, and AIDS/HIV.
6. This release of information is only valid for the person and/or agency listed above. It is not to be recopied or released to any other person or agency. However, when information is present in the record from other providers, this information may be released, UNLESS it is marked "NOT FOR REDISCLOSURE".

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this 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 this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Ohio law (Mental Health 5122.27.09), (HIV/AIDS 3701.24.3) also prohibits further disclosure of this information without the specific written consent of the person to whom it pertains.

Signature of Individual or Legal Representative

Date

Relationship to Individual

Witness

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____

Date of Birth _____ Social Security Number _____

hereby grant permission to authorized representatives of ICAN, Inc. to: (Initial all that apply)

_____ **Release records about me from the agencies specified below:**

Initial _____

_____ **Exchange information about me (VERBALLY) with the agencies specified below:**

Initial _____

_____ **Coleman Professional Services**
Initial 400 W Tuscarawas Street Ste 200
Canton, Ohio 44702
Phone: 330-438-2400

_____ **Community Services**
Initial 625 Cleveland Ave. NW
Canton, Ohio 44702
Phone: 330-455-0374

_____ **Crisis Intervention Center**
Initial 832 McKinley Ave. NW
Canton, Ohio 44702
Phone: 330-455-9407

_____ **ACTT**
Initial 832 McKinley Ave NW
Canton, Ohio 44702
Phone: 330-455-1556

_____ **Phoenix Rising Behavioral Healthcare**
Initial 1930 Fremont Place SW
Canton, Ohio 44706
Phone: 330-455-5950

_____ **Trillium Family Solutions**
Initial 624 Market Ave N
Canton, Ohio 44702
Phone: 330-454-7066

_____ Other: _____
Initial _____

The purpose of this authorization is to permit my public mental health service provider, ICAN and Basic Accommodations staff to consult with each other and make necessary and reasonable interventions to preserve the safety, sanitation and permanence of my rent subsidy and/or housing situation.

_____ I consent to the release of the above information. I am aware that this information is disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit either party from asking any further disclosures of information shared to any person/organization not specifically listed on this form without permission.
Initial _____

_____ I do not consent to release/receipt/exchange of any information.
Initial _____

Any exceptions or exclusions for information released are listed here:

AUTHORIZATION FOR RELEASE OF INFORMATION
(continued)

This authorization will remain effective for 365 days unless an earlier date or condition/event is specified

here: _____ Initials _____

1. I understand that ***I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING***, by sending/providing such written notification to Property Manager at ICAN, Inc 1214 Market Ave., N., Canton, Ohio 44714. I understand that a revocation is not effective to the extent that this Authorization has been relied upon for the use or disclosure of the protected health information.
2. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. If ICAN is the recipient, ICAN will only re-disclose information as authorized or permitted by law.
3. I understand that my housing will NOT be conditioned on whether I provide authorization for the requested disclosure.
4. I understand that I have the right to refuse to sign this authorization.
5. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted by law.

I hereby state that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly consent to disclosure of the above stated information for the purpose or need stated. I understand and acknowledge that this Authorization extends to all or any part of the records designated above.

Signature of Individual

Date

Witness

Date

**** A copy of this signed Authorization shall have the same force and effect as the original. ****

VERIFICATION OF DISABILITY
U.S. Department of Housing and Urban Development
Office of Housing Federal Housing Commissioner

Permanent Supportive Housing Voucher Program

DATE: _____

TO: (agency requested to verify information)	FROM: ICAN Housing Solutions c/o Harla Williams
Address	1214 Market Ave N
	Canton OH 44714

PLEASE RETURN THIS VERIFICATION TO THE PERSON LISTED ABOVE.

APPLICANT NAME _____

ADDRESS if applicable _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing program to verify all information that is used in determining this person's eligibility or level of benefits. Owners/management agents must obtain third party verification that a disabled individual meets the definition for persons with disabilities for the program governing the housing where the individual is applying to live.

We ask your cooperation in providing the following information and returning it to the person listed in the "FROM" box. Your prompt return of this information will help to ensure timely processing of the application for assistance. Enclosed is a self-addressed, stamped envelope for this purpose. The applicant/tenant has consented to this release of information as shown above.

INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" in the applicable box that accurately describes the person listed above.

1. ___ YES ___ NO 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 a continuous period of not less than 12 months;
2. ___ YES ___ NO Is the above a person whose disability is combined with any drug or alcohol abuse
3. ___ YES ___ NO Is the above a person whose disability is based solely on any drug or alcohol dependence (the person has no other disability which meets the above definition).

NAME, TITLE AND QUALIFICATIONS OF PERSON SUPPLYING THE INFORMATION

SIGNATURE

DATE

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

SIGNATURE

DATE

Note to Applicant/Tenant: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

PENALTIES FOR MISUSING THIS CONSENT:

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 client may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or client 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.



ICAN, Inc.

1214 Market Avenue North, Canton, Ohio 44714

Phone: (330) 455-9100 Fax: (330) 455-4702

Web: www.ican-inc.org Email: ican@ican-inc.org

INCOME, ASSET & EXPENSE STATEMENT
Supportive Housing Voucher Program

Participant Name: _____ SSN No.: _____

**Please answer each of the following questions. For each “Yes,” provide details in the chart below.
Does any member of your household:**

- Yes No 1. Work full-time, part-time, or seasonally?
- Yes No 2. Expect to work for any period during the next year?
- Yes No 3. Work for someone who pays them cash?
- Yes No 4. Expect a leave of absence from work due to lay-off, medical, maternity, or military leave?
- Yes No 5. Now receive or expect to receive unemployment benefits?
- Yes No 6. Now receive or expect to receive child support?
- Yes No 7. Not receive child support that he/she is entitled to?
- Yes No 8. Now receive or expect to receive alimony?
- Yes No 9. Have an entitlement to receive alimony that is not currently being received?
- Yes No 10. Now receive or expect to receive public assistance (TANF)?
- Yes No 11. Now receive or expect to receive Social Security or disability benefits?
- Yes No 12. Now receive or expect to receive income from a pension or annuity?
- Yes No 13. Now receive or expect to receive regular contributions from organizations or from individuals not living in the unit?
- Yes No 14. Receive income from assets including interest on checking or savings accounts, interest and dividends from certificates of deposit, stocks, or bonds, or income from rental property?
- Yes No 15. Own real estate or any assets for which you receive no income (checking account, cash)?
- Yes No 16. Have real property or other assets (including cash) that s/he has sold or given away in the past two years?

HOUSEHOLD MEMBER	SOURCE OF INCOME: NAME & ADDRESS	ANNUAL INCOME

ASSETS

1. List all checking and savings accounts (including IRAs, Keogh accounts, and Certificate of Deposit) of all household members.

HOUSEHOLD MEMBER	BANK NAME	TYPE OF ACCOUNT	ACCOUNT NUMBER	BALANCE

2. List all stocks, bonds, trusts, pensions, or other assets and their value owned by any household member:

3. List any assets disposed of for less than their fair market value during the past two years:

EXPENSES

Yes No Do you have expenses for child care of a child aged 12 or younger?
If yes, provide the name, address, and telephone number of the care provider:

What does the childcare cost you weekly? _____

Yes No Do you pay a care attendant or for any equipment for any disable household member(s) necessary to permit that person or someone else in the household to work?

If you pay a care attendant, provide their name, address, and telephone number:

What is the cost to you for the care attendant and / or the equipment? _____

Disabled / Elderly Families Only

Yes No Do you have Medicare? If yes, what is your monthly premium? _____

Yes No If you have Medicaid, do you have a spenddown? If yes, amount: _____

Yes No Do you have any other medical insurance? If yes, provided the name and address of carrier, policy number, and premium amount.

Yes No Do you have outstanding medical bills? If yes, list them below with monthly payment amounts.

What medical expenses do you expect to incur in the next 12 months?

If you use the same pharmacy regularly, please provide the name and address:

I/we understand that the above information is being collected to determine my/our eligibility. I/we authorize ICAN to verify all information provided on this income statement. I/we certify that the statements made herein are true and complete to the best of my/our knowledge and belief. I/we understand that false statements or information are punishable under federal law.

Signature of Household Member

Date



ICAN, Inc.

1214 Market Avenue North, Canton, Ohio 44714
Phone: (330) 455-9100 Fax: (330) 455-4702
Web: www.ican-inc.org Email: ican@ican-inc.org

FOR OFFICE USE ONLY
Original Sent: _____
Second Attempt: _____

TO _____
VERIFICATION SOURCE NAME

VERIFICATION SOURCE ADDRESS

DATE REQUESTED: _____
RETURN BY: _____

VERIFICATION OF EMPLOYMENT
Supportive Housing Voucher Program

PERSON / ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION FROM VERIFICATION SOURCE LISTED ABOVE:

ICAN, Inc.

ORGANIZATION

1214 Market Avenue North, Canton, Ohio 44714

ORGANIZATION ADDRESS

Harla Williams, Supportive Housing Specialist

REQUESTOR AND TITLE
(Return this verification to the person listed on this line.)

Specific purpose for requesting information:

The following participant named has applied for or is re-certifying eligibility for housing assistance under a program of the Mental Health and Recovery Services Board of Stark County (MHSRB). MHSRB requires ICAN, Inc. to verify all information that is used in determining the participant’s eligibility or level of benefits through a 3rd party.

Information participant is asking to be released:

The participant has informed us that you currently employ him/her or that they have been employed. Please provide us with the information requested below concerning the participant’s employment; hire/termination dates, hours worked, wages and/or anticipated income one year prior to the date of participant signature as indicated on the back of this form unless otherwise specified. The participant has consented to the release of information as shown by the signed consent on back of request.

THE PROMPT COMPLETION OF THIS FORM IS IMPERATIVE IN DETERMINING THE PARTICIPANT’S CORRECT BENEFIT AMOUNTS.

Participant Name: _____ Social Security No.: _____
Date of Birth: _____

OVER

Employee Start Date: _____ Present Position: _____

Termination Date: _____ Date last paycheck issued: _____

Employee works Full-time Part-time Full Year Seasonally Temporarily

Current salary or base rate pay \$ _____ per hour for _____ hours per week; or

\$ _____ per week for _____ week per years; or

\$ _____ per month for _____ months per year

Expected gross earnings during the next twelve (12) months: \$ _____

Previous twelve (12) months gross earnings \$ _____

Effective date of next salary increase (if any) _____ New rate of \$ _____ per _____

If employee works less than full time or worked less than the full year, please specify hours worked and months of the year worked:

Part-time hours worked: _____

Months of year worked: _____

Overtime pay rate per hour \$ _____ Expected OT hours for next 12 months _____

Other compensations not included above \$ _____ per _____

Specify what compensation is a result of bonus, tips, etc. _____

Name & title of person supplying information	Organization/Company
Telephone	Address

Signature

Date

Information regarding this authorization:

You do not have to sign this form if the name or address of either the person/organization requesting verification or the verification source is left blank.

You have the right to revoke this Authorization, in writing at any time prior to the expiration date to ICAN, Inc., 1214 Market Avenue North, Canton, OH 44714. The revocation is only effective after it is received and logged by ICAN. Any use or disclosure made prior to a revocation is not included as part of the revocation.

This authorization will expire (1) year from the date of your signature unless otherwise specified.

I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months from the date of my signature indicated below, unless otherwise specified (Specific date range, if applicable: _____ to _____). There are circumstances, which would require ICAN, Inc. to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

Participant Signature

Date

PENALTIES FOR MISUSING 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. SCCMHB and any owner (or any employee of SCCMHB 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 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 SCCMHB 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 42 U.S.C. 208(f)(g) and (h). Violation of these provisions are cited as violations of 42 U.S.C. 408 (f)(g) and (h).



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FOR OFFICE USE ONLY

Original Sent: _____
Second Attempt: _____

TO _____
VERIFICATION SOURCE NAME

VERIFICATION SOURCE ADDRESS

DATE REQUESTED: _____

RETURN BY: _____

VERIFICATION OF BENEFITS
Supportive Housing Voucher Program

PERSON / ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION FROM VERIFICATION SOURCE LISTED ABOVE:

ICAN, Inc.
ORGANIZATION

1214 Market Avenue North, Canton, Ohio 44714
ORGANIZATION ADDRESS

Harla Williams, Supportive Housing Specialist
REQUESTOR AND TITLE

(Return this verification to the person listed on this line.)

Specific purpose for requesting information:

The following participant named has applied for or is re-certifying eligibility for housing assistance under a program of the Mental Health and Recovery Services Board of Stark County (MHRSB). MHRSB requires ICAN, Inc. to verify all information that is used in determining the participant’s eligibility or level of benefits through a 3rd party.

Information participant is asking to be released:

The participant has informed us that s/he has applied for or is receiving benefit payments from you. Please provide us with the information requested below concerning the participant’s benefits one year prior to the date of participant signature as indicated on the back of this form unless otherwise specified. The participant has consented to the release of information as shown by the signed consent on back of request.

THE PROMPT COMPLETION OF THIS FORM IS IMPERATIVE IN DETERMINING THE PARTICIPANT’S CORRECT BENEFIT AMOUNTS.

Participant Name: _____ Social Security No.: _____

Date of Birth: _____

Type of Benefits received: _____

Current monthly benefit: \$ _____

Previous three (3) months earnings \$ _____

\$ _____

\$ _____

Other compensations not included above \$ _____ per _____

Specify what compensation is a result of bonus, tips, etc. _____

Printed name & title of person supplying information	Organization/Company
Telephone	Address

Signature

Date

Information regarding this authorization:

You do not have to sign this from if the name or address of either the person/organization requesting verification or the verification source is left blank.

You have the right to revoke this Authorization, in writing at any time prior to the expiration date to ICAN, Inc., 1214 Market Avenue North, Canton, OH 44714. The revocation is only effective after it is received and logged by ICAN. Any use or disclosure made prior to a revocation is not included as part of the revocation.

This authorization will expire (1) one year from date of your signature unless otherwise specified.

I hereby authorize the release of the requested information listed on this form. Information obtained under this consent is limited to information that is no older than 12 months from the date of my signature indicated below, unless otherwise specified (Specific date range, if applicable: _____ to _____). There are circumstances, which would require ICAN, Inc. to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

Participant Signature

Date

PENALTIES FOR MISUSING 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. SCCMHB and any owner (or any employee of SCCMHB 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 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 SCCMHB 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 42 U.S.C. 208(f)(g) and (h). Violation of these provisions are cited as violations of 42 U.S.C. 408 (f)(g) and (h).



ICAN, Inc.

1214 Market Avenue North, Canton, Ohio 44714

Phone: (330) 455-9100 Fax: (330) 455-4702

Web: www.ican-inc.org Email: ican@ican-inc.org

CERTIFICATION OF ZERO INCOME
Supportive Housing Voucher Program

Participant Name: _____ SSN: _____
Date of Birth: _____

I hereby certify that I do not receive income from any of the following sources:

1. Wages from employment (including commissions and fees).
2. Income from operation of a business.
3. Rental income from real or personal property.
4. Interest or dividends from assets.
5. Social Security payments, annuities, insurance policies, retirement funds, pensions, disability or death benefits.
6. Unemployment or disability payments.
7. Public assistance payments.
8. Alimony or child support.
9. Monetary contributions or gifts regularly received from persons not living in the unit (including rent or utility payments regularly paid on my behalf).
10. Educational grants and/or scholarships or Veterans Administration benefits available for subsistence after deducting expenses for tuition, fees and books.
11. Sales from self-employed resources (babysitting, lawn care, etc.).
12. **And**, that I have no income of any kind whatsoever at this point in time and do not anticipate income from any of the above sources within the next thirty (30) days or less depending upon the projected period of -0- income.

I understand that should I find employment or begin to receive assistance or begin to receive income from any of the sources listed above, I must report the income immediately.

Signature _____ Date: _____

WARNING: Section 1001 of Title 18 of the U. S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Supportive Housing Program Individual Service Plan Worksheet

Name			
GOALS FOR FIRST QUARTER Date of review			
A. Obtain and Remain in Permanent Housing	Supportive Services Required for Achievement	Target Date for Achievement	Date Achieved
Goal A1: Sign up for PIPP and HEAP			
Goal A2: Bring your utility bill to ICAN as soon as you receive it			
B. Increase Skills and/or Income	Supportive Services Required for Achievement	Target Date for Achievement	Date Achieved
Goal B1: Apply for all benefits for which you may be eligible. Document all your benefits for your ICAN file			
Goal B2: Enroll in an education or training course (see reverse for examples)			
C. Achieve Greater Self-Determination	Supportive Services Required for Achievement	Target Date for Achievement	Date Achieved
Goal C1: Enroll in a community program to build your support network			
Goal C2: Set up a community voice mail account with the Voucher Specialist			

MEET WITH THE VOUCHER SPECIALIST EVERY 90 DAYS TO DOCUMENT YOUR PROGRESS AND SET YOUR NEW GOALS

VOCATIONAL SERVICES

Stark County Community Action Agency
Families in Partnership
1326 Market Ave N, Canton, Ohio 44714
Phone: (330) 580-9347

Coleman Professional Services Vocational program
400 Tuscarawas Street w, Suite 200 Canton, OH 44702
(330) 438-2400

Pyramid Career Services
6363 Promway Ave NW, North Canton, OH 44720
330-305-6786

Bureau Vocational Rehabilitation
401 Market N Suite 200, Canton, OH 44702
330-438-0500

Goodwill Industries
408 Ninth Street, S. W.
Canton, OH 44707
(330) 454-9461

Employment Source
822 30th St NW, Canton, OH 44709
(330) 433-9675

Temp service or employment situation of your choice

Adult Career Technical Programs workplace assessments
Offices located on the Timken Campus
The White Building
116 McKinley Ave., N.W.
Canton, Ohio 44702
(330) 438-2556

Stark State College

Kent State Stark Campus

Apply for financial aid with the
Free Application for Federal
Student Aid (FAFSA). Apply via
www.fafsa.ed.gov.



ICAN Housing Solutions

1214 Market Avenue North, Canton, OH 44714

Phone: (330) 455-9100 Fax: (330) 455-4702

Web: www.ican-inc.org Email: ican@ican-inc.org

SUPPORTIVE HOUSING PROGRAM AGREEMENT BETWEEN ICAN, APPLICANT AND SUPPORT PROVIDER

The Housing Voucher program is funded by a grant from the Department of Housing and Urban Development (HUD). The program is designed to provide rental assistance and supportive services to assist homeless persons with disabilities make the transition from homelessness to permanent housing and maximum self-sufficiency. ICAN is required to monitor clients' achievement of permanent housing, increased income and greater self determination goals for reports to HUD.

I ELIGIBILITY

ICAN agrees to explain the responsibilities of SHP to applicants with their support provider, and assess the applicant's eligibility based on HUD requirements. ICAN will obtain third party verifications of income from DJFS or other source

Support provider will submit certifications of chronic homelessness and disability.

Support provider will accompany applicant to the initial appointment, and assist the client complete the program application.

Support provider, client and ICAN will meet quarterly to review continuation of the subsidy based on fulfilling steps toward each goal. The subsidy is dependent on documented achievement of milestones toward the goals.

I agree to the conditions of this article: ICAN initial _____ Support Provider initial _____

II PERMANENT HOUSING

ICAN agrees to provide information to landlords about benefits and responsibilities in this program, and to inspect a desired unit to ensure it meets Housing Quality Standards (HQS) established by HUD.

ICAN will pay the security deposit and subsidize the rent on a month by month basis while all parties are fulfilling their lease and program obligations.

ICAN agrees to pay utility bills the lesser of the PIP amount or the allowance amount stated in the rent calculation form. Bills must be time stamped as received by ICAN at least 10 days prior to the due date.

Client agrees to locate his/her own apartment in Stark County with a contract rent within Fair Market Rent limits established by HUD.

After ICAN inspects and passes the apartment for HQS, client will sign a lease with their landlord.

Client agrees to sign up for SMHA and other permanent housing subsidies. Client agrees to accept the first offered subsidized apartment. ICAN's subsidy ends at this point.

Client agrees to pay, by the 1st of each month, a program fee of 30% of income to ICAN. Beginning in month six, at the latest, client agrees to pay a minimum program fee of \$25 per month.

Client agrees to submit all utility bills to ICAN for payment as soon as they are received.

Support provider agrees to assist client locate an apartment, to apply for SMHA and to seek reasonable accommodation for client if SMHA determines him/her to be ineligible.

Support provider agrees to respond to Landlord's concerns about any lease violations. Landlord will call ICAN only in questions about rent payment.

Support provider and client understand that positive outcomes must be achieved to continue HUD funding. Positive housing outcomes occur only when a client leaves the SHP subsidy for permanent housing. Support provider will assist client to obtain one of the following positive housing outcomes

- | | |
|---|------------------------------------|
| a. Rental house or apartment (no subsidy) | b. Public Housing |
| c. Section 8 | d. Shelter Plus Care |
| e. HOME subsidized house or apartment | f. Other subsidized apartment |
| g. Homeownership | h. Moved in with family or friends |

I agree to the conditions of this article: ICAN initial _____ Support Provider initial _____ Client initial _____

II. INCREASED INCOME

Client agrees to develop, with his/her support provider, a plan to increase income through employment. A waiver may be requested on a case-by-case basis.

Client will immediately inform ICAN of any change in income or other circumstance that affects the program success and reporting accuracy.

Support provider, at the first quarterly meeting, will submit to ICAN the plan to reach the goals.

I agree to the conditions of this article: ICAN initial _____ Support Provider initial _____ Client initial _____

III. SELF DETERMINATION

Client and support provider agree to establish, pursue and document achievement of goals that will lead to greater self determination. Documentation will be reviewed at quarterly meetings.

I agree to the conditions of this article: ICAN initial _____ Support Provider initial _____ Client initial _____

IV. CANCELLATION OF AGREEMENT

Rental assistance will terminate automatically if the Housing Voucher contract with the Property Owner terminates for any reason.

Rental assistance will terminate after two successive quarterly review that fail to document progress toward the mandatory goal areas.

Client has the right to file an appeal using the Grievance Procedure in the case of termination.

Client may end this agreement by a 30 day written notice of intent to vacate to the landlord with a copy to ICAN. Client is responsible for paying any cost beyond the security deposit to repair any damages to the apartment, if applicable.

I agree to the conditions of this article: ICAN initial _____ Support Provider initial _____ Client initial _____

V. EQUAL HOUSING OPPORTUNITY

If the client has reason to believe that it has been discriminated against on the basis of race, color, creed, handicap, religion, sex, or national origin, it may file a complaint with the HUD Regional Office. Fair Housing Complaint Forms (Form HUD-903) are available online at www.hud.gov/complaints/housediscrim.cfm or you may obtain a form from ICAN.

KEEP THIS STATEMENT FOR YOUR RECORDS

ICAN Housing Solutions
1214 Market Ave. N
Canton, Ohio 44714
330-455-9100

Client

Address

City/Zip

Harla Williams, Supportive Housing
Specialist Signature

Date

Client Signature

Date

Provider Agency

Address Phone

Support Provider

Signature of Support Provider Date

HOUSING QUALITY STANDARD CHECKLIST

ITEM	SATISFACTORY?
Fixed basin, shower or a tub in proper operating condition with hot and cold running water. One openable window or adequate exhaust ventilation	Yes / No
Trash service and garbage cans	Yes / No
Stove, sink and refrigerator in proper operating condition	Yes / No
Space for the storage, preparation, and serving of food.	Yes / No
<u>Lockable</u> entry doors and any windows that are accessible from the outside	Yes / No
At least two means of exit in case of fire	Yes / No
Smoke detectors in proper operating condition, each level	Yes / No
Safe heating system (no room heaters). Is there a thermostat?	Yes / No
At least one window in the living room and sleeping room	Yes / No
Kitchen and bathroom must have an operating permanent light fixture and at least one operating electrical outlet	Yes / No
Living room and each bedroom must have at least two electrical outlets in proper operating condition	Yes / No
Ceilings, walls, and floors must not have any serious defects (bulging, buckling, leaning, large holes, loose surface materials, missing parts, or other serious damage)	Yes / No
Roof must be structurally sound and weather tight. Exterior wall structure must not have any serious defects	Yes / No
Interior and exterior stairs, halls, porches, walkways, etc., must not present a danger of tripping and falling	Yes / No
Neighborhood reasonably free from disturbing noises and other dangers to the health, safety, and general welfare of the occupants	Yes / No

About this tool: **This communication agreement should be filled out and signed by the tenant and then provided to the landlord to promote open communication between the landlord, tenant, and case manger. The important thing is to identify and address problems before they become irreparable.**

LANDLORD-TENANT-CASE MANAGER COMMUNICATION AGREEMENT

Dear LANDLORD:

My goal is to pay my rent on time, follow the provisions of my lease, keep my apartment in good condition, and get along with my neighbors. I am working with a program that will help me do this, but I need your help. I am asking you to inform both my case manager and me if any of the following occur. You can fill out the form and send it to the addresses below or contact us by telephone. We appreciate your cooperation.

_____ Landlord has received a complaint of too much noise from the tenant's apartment.

_____ Landlord has significant concerns about the condition of the tenant's unit. (Examples: Landlord has seen damage or received complaints about bad smells that could be related to garbage.)

_____ Landlord thinks someone is living in the tenant's unit who is not named on the lease.

_____ Landlord thinks someone in the tenant's unit may be doing something illegal.

_____ The behavior of someone living in or visiting the tenant's unit is causing other tenants to complain.

_____ Landlord has seen something that is a violation of the lease. Describe: _____

_____ Other: _____

Please contact me at the following address: _____

or call me at this number: _____

Please also contact my case manager (name): _____

at (agency/address/phone) _____

or call at this number (phone/cell/pager): _____

Thank you for your cooperation!

(Signature of Tenant)

(Date)

(Signature of Caseworker)

(Date)

ICAN, INC. GRIEVANCE PROCEDURE

Whenever a client believes that he/she has not been treated fairly or understood completely, he/she is invited to follow the grievance measures to resolve the problem. Every staff member has the continuing responsibility of advising a client or person who is articulating a concern, complaint or grievance of the name and availability of the agency's Clients' Rights Officer and the complainant's right to file a grievance. ICAN has designated a Clients Rights Officer whose responsibility it is to assist the client in using the agency's grievance procedure.

ICAN's Clients' Rights Officer and the alternate are:

Donald Williamson
Carol Duncan (alternate)

ICAN, Inc.
1214 Market Ave N, Canton, Ohio 44714
Phone: (330) 455-9100
Monday through Friday 8:00 am - 5:00 pm

A client has the right to initiate the following grievance process at any time following the occurrence of the incident.

1. Discuss the problem with the staff member involved.
2. If a satisfactory resolution cannot be reached, contact the Clients' Rights Officer who will meet with the client within two business days to discuss the grievance and attempt to resolve it with the other staff person involved. (In the event that the Clients' Rights Officer is the subject of the grievance, the Program Manager will perform that individual's duties.)
3. If a satisfactory resolution cannot be reached amongst the Clients' Rights Officer, the client and the staff person involved, a meeting will be set up with the Program Manager who will meet with the client within three business days of receipt of the grievance. The client will receive a written notification of that decision within five business days.
4. When a client's complaint moves beyond the Program Manager, it will be put in writing to establish the facts and prevent them from being changed. The Clients' Rights Officer will assist the client in completing this form, which will then be forwarded to the Personnel Committee of the ICAN Advisory Board.
5. The Committee will review the statement of the client before meeting with him/her. The Committee will then meet with the client and the staff person involved in a full and free discussion within three working days of receiving the review form. The Clients' Rights Officer will represent the client in the discussion. Within three working days the Committee will submit its decision to the client in writing.
6. If the recommendation made by the Committee still does not result in a satisfactory solution, the client will have an opportunity for a final presentation of his/her position at the executive level. Within two working days the ICAN Director and two parties named by him/her will review the facts presented by the client along with the position taken by the other parties. Within three working days the ICAN Director will present a decision in writing that is final and binding on all involved.
7. ICAN ensures every client that all statements, records and opinions resulting from the review process will be held in strictest confidence.
8. Should the complaint be of a discriminatory nature, the Clients' Rights Officer will immediately refer it in writing to the agency EEO Coordinator who will implement the agency's EEO procedures.
9. Although every effort will be made to resolve the complaint within the agency, each client has the option of filing the complaint with any of the following outside entities:

Stark County Community Mental Health Board
800 Market Avenue North
Canton, Ohio 47702 - 1075
(330) 455-6644

Ohio Legal Rights Service
8 East Long, 5th Floor
Columbus, Ohio 43215
(614) 466-7264

Ohio Department of Mental Health
30 East Broad Street, Suite 1180
Columbus, Ohio 43215
(614) 466-2596

Ohio Civil Rights Commission
South Northeast Regional Office
302 Peoples Federal Building
39 East Market Street
Akron, Ohio 44308
(216) 253-3167 (Voice/TTY)

10. Upon request, this agency will provide all relevant information about the grievance to any of the above noted entities to which the client has initiated a complaint.

A copy of this grievance procedure shall be posted in a conspicuous place within the agency. During staff orientation, every staff person will be advised of this policy and its procedures and of his/her responsibility to notify any client voicing a concern or complaint of the right to file a grievance and the Clients' Rights Officer's name and how to contact him/her.

Client Acknowledgement

I have received both a copy of this Grievance Procedure and a verbal explanation of my rights. If I have any questions about it I understand I can contact the CRO, Donald Williamson, or his alternate, Carol Duncan, at (330) 455-9100.

Client Signature

Date

ICAN, INC. CLIENT RIGHTS POLICY

It is the policy of this agency that each client has all of the following rights as found in Administrative Rule of Ohio (5122:2-1-02):

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
2. The right to service in a humane setting, which is the least restrictive feasible as defined in the treatment plan;
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;
4. The right to consent to or refuse any service, treatment or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client;
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;
6. The right to active and informed participation in the establishment, periodic review and reassessment of the service plan;
7. The right to freedom from unnecessary or excessive medication;
8. The right to freedom from unnecessary restraint or seclusion;
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or other service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan;
10. The right to be informed of and to refuse any unusual hazardous treatment procedures;
11. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies or photographs;
12. The right to consult with independent treatment specialists or legal counsel, at one's own expense;
13. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of funding and or certifying sources, state or federal statutes, unless a release of information is specifically authorized by the client or parent or legal guardian of a minor client or court appointed guardian of an adult Client in accordance with rule 22:2-3-1 1 of the Administrative Code;
14. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. Treatment reasons shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restrictions must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records.
15. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for consequences of that event;
16. The right to receive an explanation of the reasons for denial of service;
17. The right not to be discriminated against in the provision of service on the basis of religion race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability or inability to pay;
18. The right to know the cost of services;
19. The right to be fully informed of all rights;
20. The right to exercise, any and all rights without reprisal in any form including continued and uncompromised access to service;
21. The right to file a grievance, and;
22. The right to have oral and written instructions for filing a grievance.

A copy of the Clients' Rights Policy and Grievance Procedure will be distributed to each client in writing and orally at the time the client is formally provided services. In addition, an explanation and copy of this policy and the grievance procedure will be made available upon request.

In an emergency situation, the client shall be verbally advised of at least the immediately pertinent rights, such as the right to consent to or to refuse treatment and the consequences of that agreement or refusal. If the client has previously submitted "Advanced Directives" to ICAN the Agency will keep a copy of the document on file and adhere to the client's wishes as stated in it.

A copy of the Clients' Rights Policy shall be posted in a conspicuous location within the agency and every staff person shall become familiar with all specific clients' rights and the grievance procedure at the time of orientation.

For purposes of this policy, client shall include persons who receive housing, vocational or emergency assistance.

Client Acknowledgement

I have received both a copy of this Clients Rights policy and a verbal explanation of my rights. If I have any questions about it I understand I can contact the CRO, Donald Williamson, or his alternate, Carol Duncan, at (330) 455-9100.

Client Signature

Date