National Alliance on Mental Illness in Delaware
2400 West 4th Street
Wilmington, DE 19805
Phone: (302) 427-0787
Toll Free: (888) 427-2643

APPLICATION FOR HOUSING

APPLICATION MUST BE COMPLETED IN FULL

PLEASE PRINT ALL INFORMATION - DO NOT FAX

DATE___________________________

NAME____
LAST FIRST INITIAL (MAIDEN)

ADDRESS____
NO. & STREET CITY STATE ZIP

SEX__M___F DATE OF BIRTH_______________SOCIAL SECURITY #_______________

HOME PHONE #_________________________WORK PHONE #________________________

1. Race of applicant: (Select all which apply)
   For statistical purposes only.

   ___Black Or African American ____White
   ___American Indian or Alaska Native ____Asian
   ___Native Hawaiian or other Pacific Islander

2. Ethnicity of applicant (Select One): ____Hispanic or Latino
   For statistical purposes only. ____Non-Hispanic or Non-Latino

3. Is applicant handicapped or disabled? _____Yes _____No

4. Are you now living in a federally subsidized housing unit? _____Yes _____No

5. Name of complex:____

6. Name of Manager:____

7. Manager's Telephone Number:____

Signature____Date__________________________

MLF/9-2004

ALL APPLICANTS MUST COMPLETE VERIFICATION OF RENTAL HISTORY ALONG WITH ALL OTHER REQUESTED INFORMATION THAT APPLIES TO THEM.

Please provide the name, address and phone number of two personal references. You may provide the name of your next of kin or someone who knows you well.

1. ______________________________ 2. ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please provide the name, address and phone # of your Primary Physician and Social Worker (if applicable).

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Previous Rental History

Name and address of your Present Landlord:

______________________________ Telephone #______________________________

______________________________ How long have you lived there? ______________

______________________________ Reason for leaving? ______________________

Name and address of your Former Landlord:

______________________________ Telephone #______________________________

______________________________ How long have you lived there? ______________

______________________________ Reason for leaving? ______________________

Employment History

Name and address of Present Employer:

______________________________ Telephone #______________________________

______________________________ Supervisor's Name: ______________________

______________________________ How long employed there? ________________

Name and address of nearest relative NOT living with you:

______________________________ Telephone #______________________________

______________________________ Relationship: ___________________________

____

Name and address of Person to be contacted if you become incapacitated:

______________________________ Telephone #______________________________

______________________________ Relationship: ___________________________

____

SYNETICS CORPORATION

2400 W. 4th Street
Wilmington, DE 19805

TEL (302) 427-0787
TOLL FREE (888) 427-2643
TDD (302) 761-9700

VERIFICATION OF RENTAL HISTORY

Re:____(Tenant)

To:____(Current Landlord)

The above-identified person has applied for residency at_____________________________
And has indicated to us that you now have (or recently had) this person as a tenant in your property located at:____
As indicated by this person's signature noted below, the tenant consents to release of information pertaining to their rental history at____________________________________
We would greatly appreciate your cooperation in completing the applicable areas below.

1. How long has the above tenant resided at this address? ___________________________
2. How many bedrooms? ____
3. What is the monthly rental? ____
4. Has the tenant ever been behind in the payment of the monthly rent? _______________
5. How often has the tenant been late in the payment of the monthly rent? _____________
6. What type of damages, if any has the tenant caused in the unit or on common property?
   ____
7. Has the tenant been charged for any damages to the unit?
   ____
8. Has any action ever been taken against the tenant for disturbing other tenants, or controlling the behavior of children or guests? ____________________________________
9. If this tenant moved and reapplied for housing in the future, would you rent to him/her again?
   ____
10. If no, why?
    ____
11. Additional comments: ____

    ____

SIGNATURE: ____ DATE: ______________

TITLE: ____PHONE: _______________________

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 CRF 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.

Would you be kind enough to furnish the above requested information?

____ ____________________________
SIGNATURE OF APPLICANT DATE

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VERIFICATION OF PREVIOUS ASSISTED HOUSING

Re:____ __________________________
APPLICANT NAME DATE

____ __________________________
ADDRESS

In order that we may process the Housing Application on the above listed person, we would like to have your cooperation in providing the information below:

We would like for you to verify the above named person does or does not have an outstanding balance owed to you. If money is owed, the above person should make the proper arrangements to clear the balance before you verify that no money is outstanding.

Thank you for your cooperation. ____________________________ _________________
REPRESENTATIVE PHONE

I hereby verify that the above named person:
1.______Has no outstanding balance owed.
2.______Has an outstanding balance owed in the amount of $____________. At this time no arrangements have been made to pay this.
3.______Has an outstanding balance owed in the amount of $____________. Arrangements have been make to clear this balance and you are hereby released to process the application for housing.
4.______Has left the unit in violation of the lease or committed a fraud or misrepresentation regarding any information affecting eligibility or level of benefits.

____ __________________________
SIGNATURE OF LANDLORD DATE

____ __________________________
TITLE PHONE

PLEASE RETURN TO: National Alliance for Mentally Ill in Delaware
2400 West Fourth street
Wilmington, DE 19805

Would you be kind enough to furnish the above requested information?

____ __________________________
SIGNATURE OF APPLICANT DATE

SYNETICS CORPORATION

2400 W. 4th Street
Wilmington, DE 19805

TEL (302) 427-0787
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TDD (302) 761-9700

BANK VERIFICATION

(PLEASE PRINT ALL INFORMATION)

NAME OF BANK:____

ADDRESS OF BANK:____

RE:____ ______________________________
Tenant/Applicant Name Social Security Number

____
TENANT/APPLICANT ADDRESS CITY STATE ZIP

The individual named above is an applicant for housing assistance which is subsidized through the Department of Housing & Urban Development. Federal regulations require that in order for the individual to be eligible, we must verify their income, expenses and other information related to eligibility. The individual has authorized below your release of the requested information. The information you provide will be used only for the prupose of determining eligibility for the program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

____ ______________________________
NAME TELEPHONE NUMBER

I,__________________________________, hereby authorize____________________________

to release the information requested below.

______________________________________ ______________________________________
NAME SIGNATURE

____
DATE

____
ADDRESS CITY STATE ZIP

ASSETS

1. List all of your checking and savings accounts including IRAs, Keogh accounts, and Certificates of Deposit.

MEMBER #	BANK NAME	TYPE OF ACCOUNT	ACCOUNT #	BALANCE

2. List the value of all of your stocks, bonds, trusts, pensions or other assets:_______________

3. List the value of 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 is the weekly cost to you of the child care?___________________________

___ ___ Do you pay a care attendant or for any equipment for any handicapped or disabled 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?___________

___ ___ Do you have Medicare? If yes, what is your monthly premium?______________

___ ___ Do you have any other kind of medical insurance? If yes, answer the following questions:
Provide name, address of carrier, policy number and premium amount:

___ ___ Do you have outstanding medical bills? If yes, list them below:

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

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

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VERIFICATION OF EMPLOYMENT

Name and Address of Employer____

____

RE:____ SSN:_______________________
Applicant/Tenant Name

____
Applicant/Tenant Address City State ZIP

The individual named above is an applicant for housing assistance, which is subsidized through the Department of Housing & Urban Development. Federal regulations require that in order for him/her to be eligible, we must verify their income, expenses and other information related to eligibility. The individual has authorized below, your release of the requested information. The information you provide will be used only for the purpose of determining their eligibility for the program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

____ _____________________________
Name Telephone Number

I, ____, hereby authorize
Applicant/Tenant Name

____(employer) to release the information requested below regarding my employment and compensation.

Name:_____________________________ Signature:_________________________________

Date:_____________________________

____
Address City State ZIP

TO BE COMPLETED BY EMPLOYER

1. Date of Employment________________Position/Occupaton________________________
2. Date of Termination (if applicable)____
3. Current Rate of Regular Pay $___________per___________(hour, week, month, etc.)
4. Current Rate of Overtime Pay $___________per___________(hour, week, month, etc.)
5. Number hours/weeks employee normally works_________________________________
6. Anticipated average amount of overtime/week_________________________________

7. Gross annual earnings you anticipate for this employee for the next twelve months $.__________(Gross amount including all tips, bonuses, overtime, commissions.)
8. Anticipated tips, commissions, Bonuses $_______________.
9. Do you anticipate any change in the employee's rate of pay in the near future?
   Yes____ NO____ If yes: Revised Rate_____________
   Effective Date____________
10. Do you anticipate any change in the number of hours the employee works?
    Yes____ NO____ If yes, explain under #18 below.
11. Does this employee receive vacation with pay? Yes____ No____
12. Does this employee receive sick leave with pay? Yes____ No____
13. Amount deducted for medical coverage $_______________/________________
14. Amount deducted for savings plan $_______________/________________
15. If the employee's work is seasonal or sporadic, indicate lay-off period.
    ____
16. Does the employee have access to any portion of his/her pension or retirement plan account which may be withdrawn without retiring or terminating employment $__________
17. Additional comments:____
    ____
    ____
    ____

I certify that the above information is true and correct:

_________________________	_________________________
Name of Company Official	Title of Company Official
Company	Signature
Address	Date
City, State, ZIP	Telephone Number

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.

National Alliance on Mental Illness in Delaware
2400 West 4th Street
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VERIFICATION OF MENTAL ILLNESS DISABILITY

Name of Source:____

Address:____

____

RE:_____________________________________ SS#______________________________
Applicant/Tenant Name

____
Applicant/Tenant Address City State ZIP

The individual named above is an applicant for housing assistance, which is subsidized through the Department of Housing & Urban Development. Federal regulations require that in order for the individual to be eligible, we must verify information related to eligibility. The individual has authorized below your release of the requested information. The information you provide will be used only for the purpose of determining their eligibility for the program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

____ ____________________________
Name Telephone Number

I, __________________________, hereby authorize __________________________________
to release the information requested below.

_______________________________________ __________________________________
Signature Date

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TO BE COMPLETED BY THE EVALUATION DIAGNOSTICIAN

Handicap Certification: HUD's definition of handicap requires that an individual have a physical or mental handicap which: will be of long and indefinite duration; impedes the ability to live independently; and is of such a nature that the person's ability to live independently could be improved by more suitable hosing. All of the above conditions must be true to qualify as handicapped.

Based on the above definition, it is my opinion that ___________________________________
Name of Applicant

______is handicapped
______is not handicapped

Disability Certification: HUD considers a person disabled if Social Security's definition is met in paragraph (a), or the individual has a developmental disability as described in paragraph (b).

(a) Section 223 of the Social Security Act defines disability as an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or, for a blind person at least 55 years old, inability because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period.

(b) A developmental disability is a severe, chronic disability which:
(1) is attributable to a mental and/or physical impairment;
(2) was manifested before the age of 22;
(3) is likely to continue indefinitely;
(4) results in substantial functional limitations in three or more of the following areas: capacity for independent living; self-care; receptive and expressive language; learning; mobility; self-direction; and economic self-sufficiency.

____ ______________________________
SIGNATURE DATE

____ ______________________________
TITLE PHONE

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SOCIAL SECURITY VERIFICATION

Social Security Administration
92 Reads Way, Suite #200
New Castle, DE 19720

Dear Applicant:

AMID is required to verify the income of all persons applying for admission or living in subsidized housing. Please complete the form below and return to the address shown above as soon as possible. This information will only be used to determine eligibility for admission or continued occupancy. Your cooperation is appreciated.

Sincerely,

Property Manager

Applicant/Family____SS#_______________________

____
Applicant/Tenant Address City State ZIP

I authorize the release of the information below to AMID for the purposes of determining my eligibility.

____ _________________________________
Signature Date

For SS Administration Use Only

Recipient____ SS#________________________

Address____

Assistance Type:__________________________Gross Monthly Amount_____________________

__________________________ _____________________

Total_____________________

Medicare Deduction____Yes____No Amount_____________________

____ _________________________________
Signature Date

INCOME AND ASSET INFORMATION

Please answer each of the following questions. For each "yes", provide details in the charts below. Does any member of your household:

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

MEMBER #	SOURCE OF INCOME/TYPE OF INCOME	ANNUAL INCOME

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2400 West 4th Street
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Tel. (302) 427-0787
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TDD: (302 761-9700

BACKGROUND INFORMATION FORM

ADVISORY: Complete the information below in **HAND PRINTING, IN BLACK INK**. An investigation will be conducted on all information furnished on this form. By signing this form, you acknowledge your understand that the housing offered to you will depend upon the results of a background investigation. Inaccurate or untruthfulness to questions below may be the basis for refusal.

RELEASE: By signing this form, I hereby authorize any representative of InfoRetrieval Services, bearing this release, or copy thereof to obtain any information in your files pertaining to my employment, credit, licensing, disciplinary actions, and criminal history. I hereby direct you to release such information upon the request of the bearer. Consent is granted to InfoRetrieval to furnish such information as described above to Synetics Corporation only. I hereby release InfoRetrieval Services and Synetics Corp., as custodian of such records, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family or associates because of compliance wit this authorization and request to release information, or any attempt to comply with it. I am furnishing this information on a voluntary basis and have been advised by InfoRetrieval Services and Synetics Corporation this information will be used for the sole purpose of facilitating the accurate acquisition of records concerning me in connection with an application for housing. Should there be any question as to the validity of this release, you may contact me as indicated below.

____ ____________________________
SIGNATURE DATE

1. NAME (Last, First, Middle) ____

2. LIST ALL OTHER NAMES YOU HAVE USED, INCLUDING MAIDEN NAMES, MARRIED NAMES AND NICKNAMES.

_________________________________ _________________________________

_________________________________ _________________________________

3. BIRTH DATE: ______ - _____ - _____ 4. sex: _____ 5. SS: ________________ 6. Lic. ________________State Issued ______
Month Day Year M/F Social Security Number Drivers License Number/State Issued

7. HOME TELEPHONE: ______________________ 8. WORK TELEPHONE: ______________________

8. NAME OF SPOUSE(S)______________________________ 10. DATE OF MARRIAGE(S)____________________

____

11. LIST CITY, COUNTY, AND STATE OF RESIDENCE FOR PAST 7 YEARS BEGINNING WITH YOUR MOST RECENT ADDRESS

CITY	COUNTY	STATE	DATES

12. HAVE YOU EVER BEEN ARRESTED FOR A MISDEMEANOR OR FELONY OFFENSE? ☐ NO ☐ YES

This question does not apply to traffic offenses. If you have answered yes, provide the details below.

DATE OF ARREST (mm/dd/yyyy)	COUNTY/STATE OF ARREST	CHARGE	DISPOSITION

SEND THE RESULTS OF MY BACKGROUND INVESTIGATION TO:
Housing Operations Manager, Synetics Corporation, 2400 W. 4th Street, Wilmington, DE 19805

National Alliance on Mental Illness in Delaware
2400 West 4th Street
Wilmington, DE 19805
Phone: (302) 427-0787
Toll Free: (888) 427-2643

TENANT CERTIFICATION OF THE ACCURACY OF INFORMATION PROVIDED TO RECEIVE HOUSING ASSISTANCE

This information is used in determining eligibility or the level of benefits. I certify that the information I have provided is true and complete to the best of my knowledge and belief. I understand that if I furnish false or incomplete information, I can be fined up to $10,000 or imprisoned up to five years, or the lose the subsidy HUD pays and have my rent increased. I have read the Privacy Act Notice.

____ _________________________
SIGNATURE OF APPLICANT 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.

ETHNICITY AND RACIAL DATA

(Please Complete One form for every household member)

Name: (Last, First and MI)		
Relationship to Head of Household	Head of Household Co-Head of Household Other Adult Non Member	Spouse Dependent Foster/Child/Adult
Social Security Number or TRACS ID		
Ethnicity (Please Select One)	Hispanic or Latino	Non-Hispanic or Latino
Race (Please Select One)	American Indian or Alaska Native Black or African American White	Asian Native Hawaiian or other Pacific Islander

Signature ____

Date Signed __________/___________/__________

Please check this box if you are completing this form for a minor (under 18)

HEAD AND CO-HEAD MANDATORY

National Alliance on Mental Illness in Delaware
2400 West 4th Street
Wilmington, DE 19805
Phone: (302) 427-0787
Toll Free: (888) 427-2643

Release of Information Waiver

Name: ____

Address: ____

____

Home Phone: (______) ______-___________ Work Phone: (______) ______ -___________

I hereby authorize ____ to
MENTAL HEALTH PROVIDER

release information to the National Alliance for the Mentally Ill in DE (NAMI-DE) regarding any issue that may impact my independent housing opportunities.

This information may be released to the following institutions/individuals:

NAMI-DE's Housing Operations Manager

For the purpose of: Assuring the housing stability of below named individual.

______________________________ ______________________

Applicant Signature **Date**

____

Print Name

Note: I understand that my records are protected under the federal regulations governing Confidentiality of Drug Abuse Patient Records, 42 CFR Part 2, and the privacy and security of personal healthcare information, 45 CFR Parts 160-164. I understand that my records cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time including oral and written revocation except to the extent that action has been taken in reliance on it. This waiver is in effect for on year or until the tenant notifies National Alliance for the Mentally Ill in Delaware to withdraw this authorization.