Triple C Housing
Your Journey Starts Here
Care. Community. Choice.

1520 Route 130 North, Ste 201
North Brunswick, NJ 08902
Phone: (732) 297-5840
Fax: (732) 297-5851

SUPPORTIVE HOUSING AND SERVICES APPLICATION

Triple C Housing assists individuals with psychiatric disabilities who have experienced homelessness or long term hospitalizations by providing support services to find and keep housing. To be eligible for our housing services, you must have a diagnosed psychiatric illness and be in need of assistance to obtain affordable, safe housing.

Applicant Name: _____ Date: _____

Referring Agency: _____

Agency Contact Person: _____ and telephone #: _____

Applicant's Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone #(s): _____ Email: _____

Social Security #: ____-____-_____ Date of Birth: ____/____/_____

Health Insurance Type: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Uninsured

If Medicaid, please provide the member ID number: _____

US Citizen/ Legal Permanent Resident? ☐ *Yes* ☐ *No* Please circle evidence: *Birth Certificate, Passport, consular registration of birth abroad, Certificate of citizenship, certificate of naturalization, Other*: _____

Serious Mental Illness verified by psychiatric assessment: *Yes* ☐ *No* ☐

VERIFICATION OF DISABILITY, BIRTH CERTIFICATE / PROOF OF LEGAL US RESIDENCY, VALID PHOTO IDENTIFICATION, AND SOCIAL SECURITY CARD MUST BE INCLUDED OR APPLICATION WILL NOT BE PROCESSED.

Where is the applicant living this week?		☐ *Community*	☐ *Hospital*
If Hospital:	☐ *State Hospital - CEPP*	☐ *State Hospital – Non CEPP*	
	☐ *County Hospital*	☐ *Other Hospital*	
If Community:	☐ *Own Apartment*	☐ *Living with Family*	☐ *Couch Surfing*
	☐ *Rooming House*	☐ *Boarding Home*	☐ *Hotel/Motel*
	☐ *Shelter*	☐ *Car*	☐ *Street*
	☐ *Building not for habitation*	☐ *Other*:	

Other Living Situation Questions		
Gender:	☐ *Male* ☐ *Female* ☐ *Other*	
Marital Status:	☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Widowed* ☐ *Divorced*	
Does the applicant have children?	☐ *Yes* ☐ *No*	*If yes, does the applicant have custody?* _____ *Ages of children:* _____
Facing Eviction :	☐ *Yes* ☐ *No*	*If yes, pending eviction date:*
Any past evictions:	☐ *Yes* ☐ *No*	*If yes, what year?*
Domestic Violence History:	☐ *Yes* ☐ *No*	*If yes, explain:*
Roommate difficulties:	☐ *Yes* ☐ *No*	*If yes, explain:*
Living with Aging Parents:	☐ *Yes* ☐ *No*	
Aging out of DYFS:	☐ *Yes* ☐ *No*	
Trouble Paying Rent:	☐ *Yes* ☐ *No*	
TRA through Social Services:	☐ *Yes* ☐ *No*	*If yes, TRA expiration:*
Full-time Student	☐ *Yes* ☐ *No*	

Living Preference	
Do you require living alone? (never roommates/housemates)	☐ *Yes* ☐ *No*
Would you live with others if that were available first?	☐ *Yes* ☐ *No*
Do you have a roommate gender preference?	☐ *Male* ☐ *Female* ☐ *No Preference*
Do you smoke?	☐ *Yes* ☐ *No*
If you do not smoke, would you live with others who smoke?	☐ *Yes* ☐ *No*
Please list **three** New Jersey counties in order of preference:	
Please list any living accommodations required (Assisted Living, Handicap Accessible, Service Animal, etc):	

PRIMARY SOURCE OF INCOME (*provide monthly amount for all items that apply)*

$_____Social Security Disability (SSD)	$_____Supplemental Security Income (SSI)
$_____Social Security Retirement	$_____Wages/Job
$_____Public Assistance (GA or TANF)	$_____Self Employment
$_____VA or RR	$_____Unemployment
$_____Pension/Annuity	$_____Recurring Gift
$_____Other_____	

OTHER ADDITIONAL INCOME: (*provide monthly amount for all items that apply)*

$_____Child Support $_____Alimony $_____Student Financial Aid

Total Monthly Income $_____

My reason for applying to Supportive Housing: _____

_____

_____

_____

_____

I certify that the information I have provided is true to the best of my knowledge.

PRINT NAME:_____

APPLICANT SIGNATURE :_____

DATE: _____

CREDIT CHECK AUTHORIZATION RELEASE FORM

Company: Triple C Housing, Inc.

Report Choice: (please check)

Housing Court _____ Criminal _____

Please indicate purpose of request: Rental Application

For office use only

APPLICANT – PLEASE PRINT CLEARLY

Date: _____

A COPY OF BIRTH CERTIFICATE AND SOCIAL SECURITY CARD MUST BE INCLUDED OR APPLICATION WILL NOT BE PROCESSED

Last Name (print)_____ First _____ M.I._____

Social Security Number _____ Date of Birth _____

Present Address: _____

City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____

Emergency Contact Person & Phone # _____

I understand that in conjunction with my application for residency, Triple C Housing, Inc. may use the services of an outside agency to research and verify the information I have provided on my application for residency including my personal background, character and previous addresses. I hereby authorize Triple C Housing, Inc. to verify any information provided by me in this application and any supplemental attachments, including but not limited to: criminal conviction record, current and former employers and residential addresses and I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to Triple C Housing, Inc. and/or any tenant screening service they engage. I understand that the procurement of such report may contain information as to my background, mode of living, character and personal reputation. I hereby release Triple C Housing, Inc. from any liability.

By signing below, I authorize that the above information is correct and complete and authorize Triple C Housing, Inc. to obtain information it deems desirable in the processing of my application as stated above. I also understand that the information on this form may be maintained in a tenant database for up to 5 (five) years after I vacate the premises.

Print Name: _____

Signature:_____ Date: _____

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VERIFICATION OF DISABILITY

Individual Claiming Disability: _____

The above-named person is applying for participation in Rental Subsidy Program operated by Triple C Housing. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the program regulations which are as follows:

A person with a mental or emotional impairment that:

1. Is expected to be of long continued and indefinite duration; and
2. Substantially impedes his or her ability to live independently; and
3. Is of such a nature that such ability could be improved by more suitable housing conditions.

CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicated. Please describe the person's condition and include the appropriate ICD Code (F Code):

1. _____

2. _____

3. _____

Estimated duration that disability will continue: _____

APN/Physician Name: _____

APN/Physician License Number: _____

Address: _____

_____

Telephone Number: _____

APN/Physician Signature: _____ Date: _____

APN/Physician Name Printed: _____