Don't staple the pages of this application together!

1. Some providers *scan* the application, and if you staple, that means removing staples from 1000 applications every week or month.
2. If you include a letter, don't staple that either: providers need to quickly get to your waitlist data and your cover page just gets in the way.

Use #10 double-window envelopes. Fold on the line, and addresses will fit in the windows.

Dear

I am applying to the following waitlist, which I believe is open: *App Generated:*

Housing Authority or Management Office Only

Is this waitlist closed? Any other questions or concerns? *Fill in the appropriate circle(s) below and fax this page to HousingWorks at the number below – and we will correct the problem. Hundreds of thousands of applicants check our free website to see what lists are open! Keeping us updated will save you many phone calls, reduces frivolous applications - and takes only 10 minutes a year.*

O **This particular waitlist is closed: The only open waitlists we have at present are:**

____

O **This is not the correct application. The correct application is available by/from:**

____

O **Any other info you wish to tell HousingWorks?**

____

Your position or title at this housing program: __________________________________

Your signature: ____

HousingWorks Fax: **617-536-8561**

	Head of Household's FIRST Name
○	
	Head of Household's MIDDLE Name
○	
	Head of Household's LAST Name
○	

	HoH's SOCIAL SECURITY NUMBER		GENDER		HoH's DATE OF BIRTH
○		○		○	

	ETHNICITY Also provide your race at right!	RACE:	Asian , Black, White, Native American, Pacific Islander, Multi-racial Do **NOT** write Spanish, Hispanic, Latino here – and do **NOT** write your country!
○		○	

○	YOUR MOTHER'S MAIDEN NAME	

	YOUR HOME TELEPHONE	SECOND TELEPHONE
○		
	YOUR EMAIL ADDRESS	
○		

CURRENT ADDRESS OR LONG-TERM CONTACT ADDRESS

	This is:
○	
○	

	SECOND CONTACT ADDRESS
	This is:
○	
○	

	TOTAL HOUSEHOLD SIZE					# BEDROOMS			How much money does your family receive in a year?
○		# Adults		# Children	Total #	○		○	.0 0

	INCOME SOURCES
○	

	MOBILE RENTAL ASSISTANCE, if any
○	

	REQUESTED ACCOMMODATIONS
○	

	SPECIAL CIRCUMSTANCES THAT SOME PROGRAMS MAY USE TO ASSIGN PRIORITY OR PREFERENCE
○	

Supportive Living, Inc.
400 West Cummings Park
Suite 6100
Woburn, MA 01801

APPLICATION FOR HOUSING AND SERVICES

at

Warren House	McLaughlin House	Douglas House	Old Farm Rockport
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

INTRODUCTION

Supportive Living, Inc. (SLI) affordable housing properties are designed to meet the needs of people with disabilities who would benefit from the supportive services available.

Warren House is equipped to house 16 individuals and consists of 11 apartments, 5 with 2 bedrooms and 6 1-bedroom units. There is a kitchen and living room in each apartment. Each person living at Warren House has his/her own bedroom and bathroom. Common areas include a large common living room, laundry room, and an outside patio.

McLaughlin House is home to 8 individuals who each have a bedroom and bathroom. There is a large common living room, parlor, dining room, kitchen, laundry room and an outside patio.

Douglas House will accommodate 15 individuals each with their own private bedroom, bathroom, and an option for a mini kitchen. Common areas include a parlor, dining room, kitchen, laundry room, TV room, sitting area, and an outside patio and deck.

Old Farm Rockport consists of two buildings and can accommodate 6 individuals. The main building, Norwood House, has four 1st floor bedrooms. The second building, Murphy House, has two studio style bedroom units on the 1st floor.

Supportive Living, Inc., has entered into an agreement with Advocates, Inc. of Framingham, MA to provide supportive services.

Accordingly, each individual with a disability who desires to become a resident must complete two application forms and one authorization forms to release medical record information, as follows:

1. Application for Housing
2. Application for Services
3. Authorization to release Medical Record information

The instructions, on the next page, are for both applications and authorization forms.

INSTRUCTIONS

1. Please type or print all sections in black ink. Do not leave any sections blank, even those which do not apply to you. For instance, if a section asks for a driver's license and you do not have a driver's license, enter "none" or "N/A" (not applicable). If you need to make a correction, draw one line through the incorrect information. Then print the correct information above to note the change.

2. It is important that all information on both of these forms be complete and correct. False, incomplete or misleading information will cause your application to be rejected.

3. Please send your application to:

   Supportive Living, Inc.
   400 West Cummings Park #6100
   Woburn, MA 01801

4. As long as your application is on file with us, it is your responsibility to contact and inform us regarding any changes in your address, telephone number, income situation or other changes in your housing status that might affect your application.

5. After we review your application, we will make a preliminary determination of eligibility. If you appear to be eligible for housing and services, your application will be placed on a Waiting List. Having your name on the Waiting List does not guarantee that you will be offered housing. If later evaluation establishes that you are not qualified for Housing and Services, your application will be rejected and you will be so notified. We will process your application according to our standard procedures, which are summarized in the Tenant Selection Plan posted in the Management Office.

WARNING

Section 1001 of Title 18 of US Code makes it a criminal offense to make willful, false statements or misrepresentations of any material facts involving the use of or obtaining Federal funds

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

Phone: 781-937-3199
E Mail: pmorrissey@supportivelivinginc.org

APPLICATION FOR HOUSING

PLEASE TYPE OR PRINT IN INK

FULL LEGAL NAME: ____

HOME ADDRESS: ____

____ Zip: ____________

EMAIL ADDRESS or CONTACT: ____

HOME # ________________ WORK# ________________ CELL: ________________

2. SOCIAL SECURITY NUMBER: ________________ **Date of Birth:** ________________

3. THE ABOVE RESIDENCE IS:

OWN HOME: __________ NURSING HOME: ________________

PARENTS HOME: ________ REHAB CENTER: ________________

APARTMENT: __________ OTHER (SPECIFY): ____________

How did you hear about this housing opportunity (if a publication, please specify which one)?

via the HousingWorks.net website

4. IF I CAN NOT BE REACHED AT THE ABOVE NUMBER, PLEASE CONTACT:

PERSON TO CONTACT: ________________________ TEL #: ________________

RELATIONSHIP: ____________________________________

5. HAVE YOU EVER USED A DIFFERENT NAME FROM THE NAME SHOWN ABOV

NO _____ YES _____ PLEASE LIST NAMES USED AND THE DATES WHEN SUCH NAME WERE IN USE:

____

____

Is there someone currently living in your home that will not be moving in with you?
____

Do you anticipate any additions to the household in the next 12 months? _____Yes _____No
If yes, please explain______________________________

EQUAL OPPORTUNITY HOUSING

6. HAVE YOU EVER BEEN EVICTED OR OTHERWISE REMOVED FROM RENTAL HOUSING:

NO _____ YES _____ PLEASE PROVIDE LANDLORD NAME, ADDRESS AND DATES AND REASON FOR EVICTION OR REMOVAL.

____

____

____

7. HAS ANY PLACE WHERE YOU WERE LIVING BEEN DESTROYED/DAMAGED BY FIRE?

NO _____ YES _____ PLEASE PROVIDE DETAILS AND DATES:

____

____

____

____

8. LIST ALL FULL-TIME, PART-TIME AND SEASONAL EMPLOYMENT (SUPPORTIVE OR COMPETITIVE) INCLUDING SELF EMPLOYMENT WITHIN THE PAST 5 YEARS:

PLACE OF EMPLOYMENT: ____

ADDRESS: ____

CITY/TOWN/STATE: ____

TELEPHONE #: ____

DATES: FROM: ________________ TO: __________________

PLACE OF EMPLOYMENT: ____

ADDRESS: ____

CITY/TOWN/STATE: ____

TELEPHONE #: ____

DATES: FROM: ________________ TO: __________________

PLACE OF EMPLOYMENT: ____

ADDRESS: ____

CITY/TOWN/STATE: ____

TELEPHONE #: ____

DATES: FROM: _______________ TO: _________________

9. LIST NON-EMPLOYMENT INCOME AS FOLLOWS:

TYPE INCOME	ESTIMATED TOTAL $ FOR NEXT 12 MONTHS	TYPE INCOME	ESTIMATED TOTAL $ FOR NEXT 12 MONTHS
INTEREST:	___________________	UNEMPLOYMENT COMPENSATION:	____________________
DIVIDENDS:	___________________	ALIMONY:	_____________________
FROM RENTAL PROPERTY:	___________________	CHILD SUPPORT:	____________________
SOCIAL SECURITY:	___________________	WORKERS COMPENSATION:	____________________
PENSIONS:	___________________	DISABILITY COMPENSATION:	____________________
PUBLIC ASSISTANCE:	____________________	ALL OTHER INCOME:	______________________
SSI:	____________________	TOTAL INCOME:	
SSDI:	____________________		

LIST ASSETS AS FOLLOWS:

ESTIMATED ESTIMATED TYPE OF ASSET	ANNUAL INCOME CURRENT VALUE	FROM ASSETS
CHECKING ACCOUNT (S):	__________________	_________________
SAVINGS ACCOUNT (S)	_________________	_________________
TRUST ACCOUNT (S)	_________________	_________________
CERTIFICATES (CD'S)	_________________	_________________
STOCKS(S)	__________________	_________________
LIFE INSURANCE POLICY	__________________	_________________
BOND (S):	__________________	_________________
CREDIT UNION SHARES:	__________________	_________________
LAND:	__________________	_________________
REAL ESTATE:	__________________	_________________
OTHER ASSETS:	__________________	_________________

Are you applying for a Market Rate Unit? _____ Yes _____ No

Will the person/s in the household be or have been full-time students during five calendar months of this year or plan to be in the next calendar year at an educational institution. _____ Yes _____ No

IF YES, please answer the following questions:

Are any full-time student(s) married and filing a joint tax return?		
Are any student(s) enrolled in a job-training program receiving assistance under the Job Training Partnership Act (JTPA)?		
Are any full-time student(s) a TANF or Title IV recipient?		
Are any full-time student(s) a single parent living with his/her minor child who is not a Dependant on another person/tax return?		

OPTIONAL: Do you or any member of your household classify yourself as any of the following? (This may include more than one group). Responses will help us track the diversity of the applicant pool. Your entry will have no bearing on your eligibility for housing.

□ White/Caucasian □ Latino/a □ Asian/Native Hawaiian/Pacific Islander/Alaskan
□ Native American
□ Black/African-/Caribbean-American □ Another race (please specify): ___________________

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES OR NO.
PLEASE USE THIS SPACE PROVIDED TO EXPLAIN ANY YES QUESTION.

A. DO YOU RECEIVE REGULAR CASH CONTRIBUTIONS FROM AGENCIES OR FROM INDIVIDUALS NOT LIVING WITH YOU?

NO ____ YES ____ ____

B. DO YOU RECEIVE INCOME FORM ASSETS, INCLUDING INTEREST, DIVIDENDS, STOCKS, OR BONDS?

NO ____ YES ____ ____

C. DO YOU RECEIVE MONEY FROM SCHOOL-AID, SCHOLARSHIP OR EDUCATIONAL GRANT?

NO ____ YES ____ ____

D. HAVE YOU SOLD OR GIVEN AWAY ANY MONEY, REAL ESTATE PROPERTY OR OTHER ASSETS IN THE PAST TWO YEARS?

NO ____ YES ____ ____

E. DO YOU CURRENTLY USE ANY ILLEGAL DRUG OR OTHER ILLEGAL CONTROLLED SUBSTANCE?

NO ____ YES ____ ____

F. HAVE YOU EVER ENGAGED IN OR BEEN CONVICTED OF DRUG-RELATED CRIMINAL ACTIVITY, SUCH AS USE, POSSESSION, DISTRIBUTION, TRAFFICKING, OR MANUFACTURE OF AN ILLEGAL DRUG?

NO ____ YES ____ ____

G. HAVE YOU BEEN INVOLVED IN OR BEEN CONVICTED OF CRIMINAL ACTIVITY THAT POSE A THREAT TO THE HEALTH, SAFETY OR WELFARE OF OTHERS?

NO ____ YES ____ ____

__________**INITIAL**

CERTIFICATION:

I CERTIFY THAT ALL INFORMATION GIVEN IN THIS APPLICATION AND ANY ADDENDUM THERETO IS TRUE, COMPLETE AND ACCURATE.

I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS FALSE, MISLEADING OR INCOMPLETE, MANAGEMENT MAY DECLINE MY APPLICATION OR, IF MOVE-IN HAS OCCURRED, TERMINATE MY RENTAL AGREEMENT.

I AUTHORIZE THE PROPERTY MANAGER TO MAKE ANY AND ALL INQUIRIES TO VERIFY THIS INFORMATION EITHER DIRECTLY OR THROUGH INFORMATION EXCHANGED NOW OR LATER WITH RENTAL AND CREDIT SCREENING SERVICES, AND TO CONTACT PREVIOUS AND CURRENT LANDLORDS OR OTHER SOURCES FOR CREDIT AND VERIFICATION CONFIRMATION WHICH MAY BE RELEASED TO APPROPRIATE FEDERAL, STATE OR LOCAL AGENCIES.

I AGREE TO NOTIFY MANAGEMENT IN WRITING REGARDING ANY CHANGES IN HOUSEHOLD ADDRESS, TELEPHONE NUMBERS, INCOME, AND HOUSEHOLD COMPOSITION.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS APPLICATION, IN PARTICULAR, THE INFORMATION CONTAINED IN THE INSTRUCTIONS AND AGREE TO COMPLY WITH SUCH INFORMATION.

____________________ ____
DATE SIGNATURE OF APPLICANT

APPLICATION CHECKLIST

Your application is not considered complete without the following documents. Documents will not be returned; please submit copies only. Supportive Living reserves the right to request additional documentation as necessary.

Some of the Income documentation required for each household member include:

- Copies of Birth Certificate and social security card
- If applicable, SIX weeks' worth of most recent pay stubs.
- If applicable, documentation of all other sources of income you have declared (such as copies of child support, alimony, social security, or pension payments)
- If applicable, a letter and supporting documentation explaining any unusual employment or household circumstances and any other income received since the beginning of the current year (for example: bonus, inheritance etc.)
- A no-income-statement, signed and notarized, for any household member over 18 who has no source of income

SPECIAL UNIT REQUIREMENTS QUESTIONNAIRE

THIS QUESTIONNAIRE IS USED TO DETERMINE WHETHER AN APPLICANT NEEDS SPECIAL FEATURES IN THEIR HOUSING UNIT. THE NEED FOR SPECIAL ADAPTIONS MUST BE VERIFIED IN ORDER TO ASSURE THAT THE PROPER UNITS WITH SPECIAL FEATURES GO TO APPLICANTS THAT ACTUALLY NEED THE FEATURES.

APPLICANTS NAME: ____________________________________ FILE #: ___________

DATE: _________________________ I CHOOSE NOT TO COMPLETE THIS FORM: _______

APPLICANTS SIGNATURE: ____

---

1. DO YOU HAVE A CONDITION THAT REQUIRES'
:

FIRST FLOOR UNIT: ______ BARRIER FREE UNIT: _______

UNIT FOR VISION IMPAIRED: ______ UNIT FOR HEARING IMPAIRED: _______

OTHER: ____

2. CAN YOU GO UP AND DOWN STAIRS UNASSISTED?

YES ____ NO ____

3. CAN YOU OPERATE AN ELEVATOR UNASSISTED?

YES ____ NO ____

WILL YOU REQUIRE AN AID TO ASSIST YOU?

YES ____ NO ____

IF YOU CHECKED YES FOR ANY OF THE ABOVE LISTED CATEGORIES, PLEASE EXPLAIN EXACTLY WHAT YOU NEED TO ACCOMMODATE YOUR SITUATION.

____

____

____

WHO SHOULD BE CONTACTED TO VERIFY YOUR NEED FOR THE FEATURES YOU HAVE IDENTIFIED ABOVE?

NAME ____ TEL # (   ) _________________

ADDRESS ____

CITY/TOWN _______________________________________ STATE _______________

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

ADVOCATES, INC. APPLICATION FOR SERVICES

I. IDENTIFYING INFORMATION

Participant Name: ___________________________________ Tel #: (   )__________________

Present
Address _______________________________ City: ________________ State: ____ Zip: _______

Diagnosis: ____

Functional Limitations:____
____
____
____
____
____
____

Current Living Arrangements: Alone ( ) With Others ( ) Other:_____________________________________
____
____
____
____

If living with others, please describe living situation and care needed: __________________________________
____
____

Marital Status: (Circle one) S M W D Sep. Sex: M F Birthdate:__________/_______/__________

Total Monthly Income: ______________ Medicaid Card #:____

Social Security #: ___________________ Medicare #: ____________________________________

Other Insurance Specify with policy #'s: ____

Subscriber:____
____

II. CONTACT INFORMATION

A. Emergency Contact: ________________________________ Tel #: (____) ____________________

Address: ____ Relationship: ____________________

B. Emergency Contact: ________________________________ Tel #: (____) ____________________

Address: ____ Relationship: ____________________

C. Case Manager: ______________________________________ Agency: ______________________

Address: ____ Tel #: (____) ____________________

D. Guardian: ____ Tel #: (____) ____________________

Address: ____

Referred by: ______________________________ Title: _____________ Tel #: (____) ______________

Address: ____

E. Mass Rehabilitation Counselor: ____________________ Tel #: (____) __________________

Address: ____

Comments: ____

III. MEDICAL INFORMATION

Primary Care
Physician: ____ Tel #: (____) __________________.

Address: ____

Date of Last Physical: ____

Present Hospital Affiliation: ____

INPATIENT HOSPITALIZATIONS HISTORY (USE ADDITIONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Admission Date	Discharge Date

OUTPATIENT SERVICES HISTORY (USE ADDITIONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Therapies Used: Physical, Occupational, Speech, Neuropsychological, Psychological, Other…please list	Discharge Date

NURSING HOME, LONG TERM CARE, MENTAL HEALTH FACILITY HISTORY

Admission Date	Facility	Reason for Admission	Discharge Date

MEDICATION SCHEDULE

Medication	Dosage	Purpose	Prescribing Physician	Date Started

Names of other physicians involved with their telephone number:

Neurologist:______________________________Tel #:_(____)____________________

Neurosurgeon:______________________________Tel #: (____)____________________

Psychiatrist:______________________________Tel #:_(____)____________________

Other physicians involved in your care: ____

Allergies: ____

Any other significant illness or injuries: ____

IV. ASSISTANCE IN HOME

Certified Home Health Agency currently using:____

Address:____Tel #: (____)____________

Nurse (   ) Frequency:____

Home Health Aide (   ) Frequency:____

Homemaker (   ) Frequency:____

Personal Care Attendant (   ) Frequency:____

Other services needed:____

Special Equipment being used:____

Other (describe):____

Signature of person filling out this application:_______________________________________

Printed name of person filling out this application:___________________________________

Signature of applicant:____

Printed name of applicant:____

Date:____

ADVOCATES, INC.
1 Clarks Hill, Suite 305
Framingham, MA 01702

Warren House	**McLaughlin House**	**Douglas House**	**Old Farm Rockport**
17 Warren Ave.	333 Park St.	7 Oakland Street	291 Granite Street
Woburn, MA 01801	North Reading, MA 01864	Lexington, MA 02420	Rockport, MA 01966

AUTHORIZATION FORM
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name:_________________________________ **DOB**:__________________

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information designated below between:

Staff at Warren House, McLaughlin House, Douglas House or Old Farm Rockport
Clinician/Staff

Or Advocates staff at Advocates, Inc. 1 Clarks Hill, Suite 305, Framingham, MA 01702

And the following person / Organization:

Supportive Living, Inc. (SLI)
Print Name
400 West Cummings Park, Suite 6100, Woburn, MA 01801
Print Address

Health information includes information collected from me or created by the above Providers, or information received by the above Providers from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I further understand that Advocates and its employees are prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2).

I further understand that under state law Advocates and its employees are prohibited from disclosing information about my HIV status without my specific written authorization. Advocates and its employees are also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed consent," except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

Check appropriate boxes:

Health Information that may be used or disclosed through this Authorization is as follows:

_X_ All health information about me, including my clinical records, created or received by Advocates or any of its employees and the above listed Provider/Organization. This information may include, if applicable:

____ Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse; Specifically for the following purpose(s)________________________________

____ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.

Specifically for the following purpose(s)________________________________

___ Information regarding the results of a genetic test.

- Specific information including only: ____
____
____
____

This Authorization expires: ____________ upon discharge from the program ____________
(Insert applicable event or date – mm/dd/yy)
(Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure).

1. I understand that Advocates and its employees cannot guarantee that PHI disclosed to the above indicated Person/Organization will not be re-disclosed to a third party. The Person/Organization may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the Person/Organization is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Advocates, Inc, except when (i) my refusal may limit Advocates ability to provide safe and effective care (ii) I am receiving research-related treatment or (iii) receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Advocates or its employees in reliance on this Authorization before written notice of revocation is received by Advocates or its employees. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Advocates, Inc. 27 Hollis St., Framingham, MA 01702

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: ______________________________ Date of signature: __________

Print Client's full name: ____

Client's Home Address: ____

Client's Home Telephone: ______________________________ Date of Birth: __________

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative: ______________________________ Date of signature: __________

Print name: ____

Relationship of representative to client: ____

AGENCY CODE: XSLIVI
FEE EXEMPTION CODE: FE411

Supportive Living, Inc.

CORI REQUEST FORM

Supportive Living Inc. (SLI) has been certified by the Criminal History Systems Board for access to Criminal Offender Record Information (CORI) pursuant to M.G.L c. 6, Paragraph 172(b) and/or 172(c). SLI has been granted access for the purpose of tenant selection only, and shall not be otherwise used or disseminated. **By signing below, I provide my consent to a CORI check and acknowledge that the information provided is true an accurate.**

______________________________ ____________

APPLICANT/EMPLOYEE SIGNATURE DATE

APPLICANT/EMPLOYEE SIGNATURE INFORMATION (PLEASE PRINT)

__________________ ____________________________ __________________

LAST NAME FIRST NAME MIDDLE NAME

________________________ _______________

MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

_________________________ ______ - ______

DATE OF BIRTH LAST SIX DIGITS OF YOUR SOCIAL SECURITY NUMBER

ID THEFT INDEX PIN: (If applicable) ____________

____________________ ____________________

MOTHER'S FULL MAIDEN NAME FATHERS FULL NAME

CURRENT AND FORMER ADDRESSES:

____

____

SEX: _______ HEIGHT: __ft. __ in. EYE COLOR: ______ RACE__________

DRIVER'S LICENSE NUMBER or ID NUMBER_________ STATE of ISSUE____

*** THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM(S) OF GOVERNMENT ISSUED IDENTIFICATION:

____

____

____

VERIFIED BY: ____

SIGNATURE OF CORI AUTHORIZED EMPLOYEE

* The CHSB Identify Theft Index Pin Number is to be completed by those applicants that have been issued an Identify Theft Index Pin Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.