Pre-Application to Be Placed on Waitlist

EDEN-Owned Scattered Sites & HUD Housing

Thank you for expressing interest in our housing program. Enclosed is the application to be placed on a waitlist for our scattered site program.

- At least one person in the household must be 18 years old or older.
- The head of the household must have a documented severe mental health disability and must be linked with services through a contract mental health agency of the ADAMHS board. The enclosed Disability Verification form must be signed by an independent licensed clinician, an LISW, a physician, psychologist or psychiatrist.
- The pre-application must be completed by the Head of Household.
- EDEN must receive copies of a photo ID for each member of the household that is 18 years or older.

In order to be considered for the Rental Program you must submit all of the following documentation.

- Pre-Application .... (Must be completed by Head of Household)
- Disability Verification Form...... (Must be signed by licensed professional for Head of Household)
- Copy of Photo I.D. .... (Each person 18 years old & older)

There are 3 ways to submit the pre-application, disability verification form, and a copy of the photo IDs:

1. **Take it to EDEN headquarters at 7812 Madison Ave, Cleveland OH 44102 (Bus #25; there is a stop in front of EDEN headquarters).** NOTE: EDEN cannot copy documents for you. Bring a copy of a photo ID for each person in the household 18 years & older. If you want a copy of the application, be sure to make one before you come to EDEN. *You can make up to 10 copies at any branch of the public library at no cost. The library will also copy your photo ID at no cost.*

2. **Mail it to EDEN. Your envelope must be postmarked August 4th or earlier.**

   EDEN Waitlist
   7812 Madison Ave
   Cleveland, OH 44102

3. **Fax it to (216) 651-4066**

Applications can be submitted on July 31st, 2023, through August 4th, 2023, at 4:00 pm. Any application not received by that time will be denied.

ADAHMS Contract Agencies

To be eligible for this housing program, the head of household must be linked to services through a contract mental health agency of the ADAMHS board. The following list contains the current contracted agencies. If you are not linked to an agency and wish to receive mental health services, you can contact any one of those below. Simply click on the link to learn more about the agency.

- **99Treasures Arts & Culture**
- **Achievement Centers for Children**
- **Applewood Centers**
- **Asian Services in Action, Inc.**
- **Beech Brook**
- **Bellefaire Jewish Children's Bureau**
- **Benjamin Rose Institute on Aging**
- **Birthing Beautiful Communities**
- **Briermost Foundation**
- **Catholic Charities Corporation**
- **The Centers for Families and Children**
- **Circle Health Services (Part of The Centers)**
- **Cleveland Rape Crisis Center**
- **Cleveland Treatment Center**
- **Colors+**
- **Community Action Against Addiction**
- **Community Assessment & Treatment Services, Inc.**
- **Community Medical Services**
- **Cornerstone of Hope**
- **Courage to Caregivers, Inc.**
- **East Cleveland Neighborhood Center**
- **Emerald Development and Economic Network, Inc. (EDEN)**
- **Epilepsy Association**
- **Far West Center**
- **Friendly Inn Settlement**
- **FrontLine Service**
- **Front Steps Housing & Services**
- **Future Directions**
- **Galilean Theological Center**
- **Golden Ciphers**
- **Hispanic UMADAOP**
- **Hitchcock Center for Women**
- **I'm In Transition, Ministries**
- **It's Not a Moment, it's a Movement**
- **Jewish Family Service Association (JFSA)**
- **Jordan Community Residential Center**
- **Journey Center for Safety and Healing**
- **Joseph's Home**
- **The Life Exchange Center**
- **Lutheran Metropolitan Ministry**
- **Magnolia Clubhouse**
- **May Dugan Center**
- **MetroHealth System**
- **MetroHealth - The Moms House**
- **Moore Counseling and Mediation Services**
- **Murtis Taylor Human Services System**
- **Music Settlement**
- **Naaleh Cleveland, Inc.**
- **NAMI of Greater Cleveland**
- **New Directions, Inc.**
- **Northcoast Behavioral Healthcare**
- **Northern Ohio Recovery Association**
- **OhioGuidestone**
- **Oriana House, Inc.**
- **People, Places and Dreams**
- **Positive Education Program**
- **Project LIFT Services**
- **Providence House**
- **Recovery Resources**
- **Recovery Solutions of Northeast Ohio**
- **Salvation Army Harbor Light Complex**
- **Scarborough House**
- **Shaker Heights Youth Center**
- **Signature Health**
- **Stella Maris, Inc.**
- **St. Vincent Charity Medical Center, Rosary Hall**
- **Thrive Peer Support**
- **Trinity Outreach Ministries**
- **University Settlement**
- **Women's Recovery Center**
- **YMCA (Y-Haven) of Greater Cleveland**

Pre-Application
EDEN-OWNED Scattered Sites & HUD Housing Waitlist

Who will live in the apartment:

Full Name	Relationship to Head	Birth Date	Gender	Social Security #	Race	Ethnicity Circle Choice
	Head of Household					Hispanic Not Hispanic
						Hispanic Not Hispanic
						Hispanic Not Hispanic
						Hispanic Not Hispanic
						Hispanic Not Hispanic

1. Are you a US Citizen? .... ☐ YES ☐ NO

2. Have you ever been convicted of a Felony? .... ☐ YES ☐ NO

3. Have you ever maintained your own housing unit?... ☐ YES ☐ NO

4. Are you currently homeless? .... ☐ YES ☐ NO

5. Are you (or any household member) a registered sex offender?........................ ☐ YES ☐ NO

6. Has any of your previous dwellings been damaged by fire? .... ☐ YES ☐ NO

7. Do you need a handicap accessible unit?... ☐ YES ☐ NO

8. Have you ever resided in EDEN-Owned Housing?... ☐ YES ☐ NO

9. Are you able to put utilities in your name?... ☐ YES ☐ NO

10. Do you meet the required disability criteria for EDEN Housing? .... ☐ YES ☐ NO

11. Are you a full-time student? .... ☐ YES ☐ NO

**A full-time student is defined as someone who will be a full-time student for five months this year, not necessarily consecutive.*

12. Please Circle Preferred Location:

☐ East Side ☐ West Side ☐ First Available

Name of Head of Household: ____

Current address:	
Phone:	Email Address:
Case Management/Partner Agency Name and Phone Number:	

ANNUAL INCOME

Include anticipated income from all sources for the next twelve months.

Source	**Head of Household**	**Other Household Member**	**Other Household Member**	**Total**
Gross Employment Income (Include overtime, tips, etc.)				
Net Income from Self – Employment and/or Business				
Social Security, Pensions, Annuities, Insurance Settlements				
Unemployment Compensation or Severance Pay				
Workers Compensation, Disability or Death Benefits, Veteran's Benefits				
Alimony, Child Support (Receiving)				
OWF or Other Public Assistance, Recurring Monetary Gifts				
Other:				
Total Anticipated Income:				

____ ___________________________

Applicant Signature Date

____ ___________________________

Social Worker Signature/Name of Employer Date

Date/Time Received:_____________________________ Received By: ____________________________

Approved/Denied Reason: ________________________ Processed by: ___________________________

Notification Sent Date: __________________________ Scanned to Onbase By: ____________________

Disability Verification Form

Revised 7.2020

Date of Verification: ______________________________

Last Name: ____________________________________ First Name: ____________________________________

Referring Agency: ________________________________ Case Manager: ________________________________

For the purpose of this program, the applicant/tenant must meet the following criteria: a) As a result of her/his disability, the need for treatment is expected to be of a long, continued, and indefinite duration; b) The disability substantially impedes her/his ability to live independently; and c) The disability is of such nature that it could be improved by more suitable housing conditions. If the participant is disabled by chronic problems with alcohol and/or drugs, the problematic use must have occurred for at least 12 months and caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

Primary Disability:	**Secondary Disability:**
☐ Mental Health	☐ Mental Health
☐ HIV/AIDS	☐ HIV/AIDS
☐ Drug Abuse	☐ Drug Abuse
☐ Alcohol Abuse	☐ Alcohol Abuse
☐ Alcohol and Drug Abuse	☐ Alcohol and Drug Abuse
☐ Chronic Health Condition	☐ Chronic Health Condition
☐ Developmental Disability	☐ Developmental Disability
☐ Physical	☐ Physical
☐ Other (Please Specify): __________________	☐ Other (Please Specify): __________________

Disability Status:

☐ Currently receiving SSI/SSDI   ☐ Not currently receiving SSI/SSDI

____ ______________________________

Signature of Independently Licensed Clinician   Date

____ ______________________________

PRINT name of person signing form   License Number

____

Title of person signing form