Supportive & Affordable Housing for Adults with Disabilities

Cohome™ journey

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1 BR & 2 BR Apartments

Apply Online

www.cohome.org/journey

Do you or someone you know have a disability and want to live independently, with supports? Apply today to join one of these 14 new affordable apartments for adults with intellectual and/or developmental disabilities (I/DD)! Applicants must have an I/DD and qualify as low-to-moderate income for Morris County. Qualified individuals are welcome to apply online or in-person at the leasing office located at 175 Morris Street, Morristown, NJ.

Questions? Email us at journey@cohome.org

45 S Park Pl STE 8, Morristown, NJ 07960 | journey@cohome.org | www.cohome.org/journey | 973.975.0778

175 MORRIS STREET, MORRISTOWN
SUPPORTIVE HOUSING
RENTAL APPLICATION CHECKLIST

The following forms are REQUIRED in order for your application to be considered:

1. Questionnaire
2. Completed Rental Application
3. One (1) copy of a form of government-issued identification: Picture ID, Birth Certificate, Social Security Card, Driver's License, etc.
4. Most recent bank statement and documentation for all sources of income (i.e., pay stubs, SSI award letter, child support, alimony, IRA and 401K investments, pension payments, etc.)
5. Disability certification form completed by a licensed physician
6. Proof of medical insurance/coverage
7. Copy of the first page of the DDD Support Plan (if applicable)

Submit the application by email at journey@cohome.org or by mail to 45 S. Park Pl., STE 8, Morristown, NJ 07960. For questions or assistance, please contact the Cohome Journey Program at jourey@cohome.org.

INSTRUCTIONS

Thank you for your interest in living with us! Cohome, LLC was founded to create opportunities for adults with disabilities to access their communities. We make independence accessible through person-centered affordable housing and supportive services. The decision to enroll in any supportive housing program is significant and we look forward to supporting you on your journey.

When completing this application, please select the answer that best reflects an applicant's abilities; there are no "right" answers. Simply, this application helps us learn more about an applicant and ensure the applicant qualifies for the program. Cohome welcomes applicants of all abilities.

This project's affordable supportive housing units are designated for individuals with intellectual and/or developmental disabilities (I/DD). To ensure an applicant qualifies, the applicant must provide a doctor's letter that documents that s/he has a chronic physical and/or intellectual impairment that 1) manifested in the developmental years, before age 22; 2) is lifelong; and 3) substantially limits the individual in at least three of the following life activities: self-care; learning; mobility; communication; self-direction; economic self-sufficiency; and the ability to live independently. There is a document at the end of this application your doctor must complete.

If the individual completing the application is not the prospective tenant, select answers appropriate for the prospective tenant, unless otherwise instructed.

To complete this application you will need to attach certain forms including proof of income (i.e. pay-stubs, SSDI, etc.) and share information related to the applicant's disability. It is recommended to have the applicant's DDD Individualized Supports Plan on-hand before completing this application.

Once an application has been received and reviewed you will be notified of any decision after the enrollment period. A team member may reach out for clarification or additional information. Cohome, LLC operates in compliance with federal and state housing laws. **Submit the application by email at journey@cohome.org or by mail to Cohome, LLC, 45 S. Park Pl., STE 8, Morristown, NJ 07960.**

NOTICE: INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED.

QUESTIONNAIRE

1. What do you enjoy doing in your free time?

2. What is your favorite thing to watch on TV?

3. What is your favorite food?

4. Do you like to listen to music? If so, what type do you like best?

5. When you have a problem or a question, who do you talk to?

6. What time do you usually wake up?

7. What time do you usually go to bed?

8. Who do you live with right now?

9. Have you ever lived independently such as in college, in a group home, or in an apartment of your own?

10. How do you feel about living in your own apartment?

11. Did someone help you answer these questions and if so, who?

RENTAL APPLICATION

To complete the application, please answer all of the questions below. Please note: This development includes one- and two-bedroom apartments. You do not need to specify if you want a one- or two-bedroom. That decision will be made by Cohome, LLC after carefully reviewing applications and conducting interviews. Roommate pairings are made based upon common likes and dislikes as well as schedule.

If you have any questions, please contact our Support Helpdesk at journey@cohome.com.

Personal Information

Today's Date (mm/dd/yyyy): _____/_____/_____

Applicant's Full Name: _____

Date of Birth (mm/dd/yyyy): _____

Social Security Number: _____-_____-_____

Street Address: _____

City/State/Zip Code: _____

Home Phone: (_____) _____-_____

Mobile Phone: (_____) _____-_____

E-mail Address: _____

How did you hear about this housing opportunity?

- ☐ Word-of-mouth
- ☐ Online advertisement
- ☐ Promotional email

☐ Other: _____

Parent/Guardian/Alternate Contact's Full Name: _____

Daytime Phone Number: (_____) _____-_____

Cell Phone Number: (_____) _____-_____

Street Address: _____

City/State/Zip: _____

E-mail Address: _____

In your own words, describe your developmental disability and level of independence:

_____

_____

_____

_____

_____

_____

_____

What agency, company or private individual(s) is providing you with support services? List all that apply. Do not include DDD, Medicaid or Social Security.

Provider/Agency Name: _____

Provider's Address: _____

Provider’s Phone Number: _____

Contact Person: _____

How are services paid for? _____

How many hours per week do you, or do you plan to, receive support from this provider?

- ☐ Less than 10 hours
- ☐ 10 through 20 hours
- ☐ 20 through 40 hours
- ☐ 40+ hours

Do you have a budget from DDD?

- ☐ Yes
- ☐ No

If yes, what budget program? Include this budget when you submit your application.

- ☐ Community Care Program (formerly the Community Care Waiver)
- ☐ Supports Program
- ☐ Self-Directed Services
- ☐ Approved for DDD services but my budget is pending

If you answered "Yes" to the above, what is your NJ CAT Tier Assignment?

- ☐ A
- ☐ B
- ☐ C
- ☐ D
- ☐ E

If you answered "Yes" to the above, do you have an acuity factor?

- ☐ Yes
- ☐ No

If you answered "Yes" to the above, please describe.

_____

_____

_____

Do you take any medications?

- ☐ Yes
- ☐ No

If you answered "Yes" to the above, please list medication names and your reason for taking.

_____

_____

_____

Do you need nursing or medical care on a daily basis?

- ☐ Yes
- ☐ No

If you answered “Yes” to the above, please explain: _____

_____

_____

_____

Which daily activities do you participate in?

- ☐ Employment
- ☐ School
- ☐ Volunteering
- ☐ Day Program (Day Habilitation)
- ☐ Job Training

Do you drive?

- ☐ Yes
- ☐ No

If you answered “Yes” to the above, do you own a car?

- ☐ Yes
- ☐ No

A background check will be conducted on each application. Findings may

result in this application being disqualified.

Do you have any felonies or misdemeanors? If yes, check all that apply.

- ☐ Sexual misconduct.
- ☐ Illegal possession, manufacture, sale and/or distribution of a controlled substance.
- ☐ Physical crime against a person or persons and/or another person's property.

Do you have any history of behavioral or emotional difficulties (aggressiveness, self-harm, threatening, depression, violent ideation)?

- ☐ Yes
- ☐ No

If you answered "Yes" to the above, please explain: _____

_____

_____

_____

Have you ever been party to a lawsuit?

- ☐ Yes
- ☐ No

If you answered "Yes" to the above, please explain: _____

_____

_____

Financial Information

Check all of the sources of income that you receive. Include current documentation for each of the items that you check. Include the amount in the space provided.

Supplemental Security Income

- ☐ Yes

☐ No

If yes, what is the annual amount? _____

Social Security Disability Insurance

☐ Yes

☐ No

If yes, what is the annual amount? _____

Social Security Retirement

☐ Yes

☐ No

If yes, what is the annual amount? _____

Employment

☐ Yes

☐ No

If yes, what is the annual amount? _____

Unemployment

☐ Yes

☐ No

If yes, what is the annual amount? _____

Pension

☐ Yes

☐ No

If yes, what is the annual amount? _____

Alimony

☐ Yes

☐ No

If yes, what is the annual amount? _____

Welfare

☐ Yes

☐ No

If yes, what is the annual amount? _____

Supplemental Trust

- ☐ Yes
- ☐ No

If yes, what is the annual amount? _____

Housing Voucher

- ☐ Yes
- ☐ No

If yes, what is the annual amount? _____

Other

If other, please specify the type and annual amount. _____

_____

_____

_____

Do you have a savings and/or checking account?

- ☐ Yes, I have my own account
- ☐ Yes, I have a joint account
- ☐ No

If yes, complete the following:

Name of Bank or Credit Union _____

Address _____

Phone Number _____

Account Number _____

Current Balance _____

Do you own stocks or bonds?

- ☐ Yes

☐ No

If yes, please provide the company name and address for each. _____

_____

_____

_____

Do you own real estate?

☐ Yes, by myself

☐ Yes, jointly

☐ No

If yes, what is the value? _____

Certification of Applicants

Please read this section carefully. It is very important.

I/We certify the information given in this application is accurate and complete. I/We further understand that any inaccuracies or information withheld may be the basis for immediate denial of my application by the Owner/Agent. I/We, by signature below, authorize the Owner/Agent to request a complete criminal background check through an outside independent background service company to secure a written report of all information pertaining to [but not limited to] sex offender records, criminal background, etc. I/We further agree that this application does not constitute any oral and/or written commitment on the part of the Owner/Agent. I/We understand the Owner/Agent will request only that information necessary to determine the person's eligibility or level of assistance.

Please be further advised:

Federal law prohibits the Landlord from discrimination against any applicant because of race, color, creed, religion, sex, national origin, political or other affiliation, family status, handicap, or source of income. As required by federal law, applicants must produce proof of their social security numbers. Individuals who have not been assigned a social security number are required to sign and date a certification stating that a social security

number has not been assigned. This certification requires subsequent compliance should this apply.

Signature of the Applicant	Date (mm/dd/yyyy)
Signature of the Guardian, if applicable	Date (mm/dd/yyyy)

AUTHORIZATION FOR RELEASE OF INFORMATION

Consent
I authorize and direct any Federal, State or local agency, organization, business, or individual to release to Cohome, LLC any information or material needed to complete and verify my application for tenancy.

I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) or the NJ Department of Community Affairs (DCA) in determining possible rental assistance.

Information Covered
I understand that, depending on the program policies and requirements, previous or current information regarding myself may be needed. Verifications and inquiries that may be requested include, but are not limited to 1) Identity and marital status, 2) Residences and rental activity, 3) Credit and criminal activity, 4) Employment income and assets, 5) Social Security benefits and 6) Medical or child care allowances.

Groups or Individuals That May Be Asked
The groups or individual(s) that may be asked include, but are not limited to: 1) Previous landlords, 2) Schools and/or colleges, 3) Social Security Administration, 4) Banks and other financial institutions, 5) County Welfare Agencies, 6) Law enforcement agencies, 7) Past and present employers, 8) Utility companies and 9) Social services providers.

Computer Matching Notice and Consent
I understand and agree that HUD, NJ DCA or Cohome, LLC may conduct computer matching programs to verify the information supplied for my application or recertification. If a computer match is done, I understand that I have the right to a notification of any adverse information found and an opportunity to disprove incorrect information. HUD or NJ DCA may in the course of its duties exchange such automated information with other Federal, State or local agencies, including but not limited to: State Employment Security Agencies, Department of Defense, Office of Personnel Management, the U.S. Postal Service, The Social Security Administration, and State Welfare and Food Stamp agencies.

Conditions

I agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file with Cohome, LLC and will stay in effect for the life of tenancy. I understand that I have the right to review my file and correct any information that I can prove is incorrect.

Signature of the Applicant	Date (mm/dd/yyyy)
Signature of the Guardian, if applicable	Date (mm/dd/yyyy)

DISABILITY CERTIFICATION FORM

This form is to be completed by a licensed physician.

Identifying Information		
Individual's Name:	D.O.B.:	
Last 4 Digits of Social Security Number:		
Circle Applicable Codes		
PRIMARY ICD-9 CODES	ICD-9 CODE	ICD-10 DIAGNOSTIC CODE
Abetalipoproteinemia	272.5	E78.6
Acrocephalosyndactyly (Apert's Syndrome)	755.55	Q87.0
Adrenaleukodystrophy	277.86	E71.529
Arginase Deficiency	270.6	E72.21
Agenesis of Septum Pellucidum	742.2	Q04.3
Argyria/Pachygyria/Microgyria	742.2 Or 758.33	Q04.3
Aicardi Syndrome	333	G23.8
Alcohol Embryo and Fetopathy	760.71	F84.5
Anencephaly	655.0	Q00.0
Angelman Syndrome	759.89	Q93.5
Asperger Syndrome	299.8	F84.5
Ataxia-Telangiectasia	334.8	G11.3
Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)	299.0	F84.0
Biotinidase Deficiency	277.6	D84.1
Canavan Disease	330.0	E75.29
Carpenter Syndrome	759.89	Q87.0
Cerebral Palsy, unspecified	343.69	G80.9
Cerebral Palsy, Hemiplegic, Congenital	343.1	G80.2
Cerebral Palsy, Paraplegic, Congenital	343	G80.1
Cerebral Palsy, Quadriplegic	343.2	G80.0
Charcot Marie Tooth Disease	356.1	G60.0
CHARGE Association	759.89	Q89.8
Cockayne Syndrome	759.89	Q89.8
Coffin-Lowry Syndrome	759.89	Q89.8
Congenital Defects of Glycosylation	279.03	D80.3
Cornelia de Lange Syndrome	759.89	Q89.8
Cri-du-chat Syndrome	758.31	Q93.4
Crouzon Syndrome	756.0	Q75.1
DiGeorge Syndrome	279.11	D82.1
Down Syndrome	758.0	Q90.9

Dubowitz Syndrome	742.8	Q07.8
Duchenne Muscular Dystrophy	359.1	G71.0
Dystonia Musculoram Deformans	333.6	G24.1
Encephalopathy, not elsewhere classified	348.3	G93.40
Epilepsy, unspecified	345.9	G40.90
Fetal Alcohol Syndrome	760.71	Q86.0
Fragile X Syndrome	759.83	Q99.2
Friedreich's Ataxia	334.0	G11.1
Fucosidosis	271.8	E77.1
Gaucher's Disease	272.7	E75.22
Generalized Convulsive Epilepsy	345.1	G40.309
Generalized Non-Convulsive Epilepsy	345.0	G40.401
Gonadal Dysgenesis (Turner's Syndrome)	758.6	Q96.9
Grand Mal Status	345.3	G40.409
Other Spinocerebellar Diseases (Ataxia-Telangiectasia (Louis-Bar Syndrome)	334.8	G11.3
Hallervorden-Spatz Syndrome	333.0	G23.0
Head Injury, unspecified – Age of onset	959.01	S09.90XA
Hemiplegia, unspecified	342.9	G81.90
Holoprosencephaly	742.2	Q04.2
Homocystinuria	270.4	E72.11
Huntington's Chorea	333.4	G10
Hurler's Syndrome	277.5	E76.01
Hyperammonemia Syndrome	270.6	E72.4
I-Cell Disease	272.2	E77.0
Idiopathic Torsion Dystonia	333.6	G24.1
Incontinentia Pigmenti	757.33	Q82.3
Infantile Cerebral Palsy, unspecified	343.9	G80.9
Intractable Seizure Disorder	345.1	G40.309
Klinefelter's Syndrome	758.7	Q98.4
Krabbe Disease	333.0	E75.23
Kugelberg-Welander Disease	335.11	G12.1
Larsen's Syndrome	755.8	Q74.8
Leigh Disease	330.8	G31.82
Lesch-Nyhan Syndrome	277.2	E79.1
Lissencephaly	742.2	Q04.3
Lowe (Terrey MacLachlan) Syndrome (Oculocerebrorenal Dystrophy)	270.8	E72.03
Marfan Syndrome	759.82	Q87.40
Megalencephaly	742.4	Q04.5
Menkes Disease (X-Linked)	275.1	E83.09
Metachromatic Leukodystrophy	330.0	E75.25
Methylmalonic Aciduria (Acidemia)	270.3 or 270.7	E71.120
Microencephaly	742.1	Q02
Mild Intellectual Disability	317.0	F70
Mixed Conductive and Sensorineural Hearing Loss	389.2	H90.8
Moderate Intellectual Disability	318.0	F71
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.1	H54.10

Mucolipidosis Type IV	330.1	E75.11
Mucopolysaccharidosis (Hunter's Syndrome, Hurler's Syndrome, Scheie's Syndrome)	277.5	E76.01
Multiple Sclerosis	340	G35-37
Neuroaxonal Dystrophy	333	G23.0
Neurofibromatosis (von Recklinghausen's Disease)	237.71	Q85.01
Neuronal Heterotopia	742.8	Q07.8
Niemann-Pick Disease	272.7	E75.249
Noonan Syndrome	759.81	Q87.1
Other Cerebral Degeneration Nonspecified	331.8 Or 349.89	G32.89
Other Chromosomal Abnormalities, not elsewhere classified	758.89	Q99.8
Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)	277.2	E79.1
Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)	759.9	Q87.1
Other Specified Anomalies of Nervous System (Familial Dysautonomia; Riley-Day Syndrome)	742.8	G90.1
Other Specified Cerebral Degenerations in Childhood (Alper's Disease or Gray-Matter Degeneration; Infantile Necrotizing Encephalomyelopathy; Leigh's Disease; Subacute Necrotizing Encephalopathy or Encephamyelopathy, Rett's Syndrome)	330.8	G31.81
Other Specified Pervasive Developmental Disorders (Asperger's Disorder, Atypical Childhood Psychosis; Borderline Psychosis of Childhood)	299.8	F84.5
Paraplegia (Paralysis of Both Lower Limbs)	344.1	G82.20
Partial Epilepsy, with Impairment of Consciousness (Psychomotor Epilepsy)	345.4	G40.201
Patau's Syndrome	758.1	Q91.7
Pervasive Developmental Disorder- NOS	299.9	F84.9
Pick's Disease	331.11	G31.01
Propionic Acidemia	270.3	E71.121
Prader-Willi Syndrome	759.81	Q87.1
Profound Intellectual Disability	318.2	F73
Pyruvate Dehydrogenase Deficiency	271.8	E74.4
Quadriplegia and Quadriparesis	344.00	G82.5
Refsum's Disease	356.3	G60.1
Rett's Syndrome	330.8	F84.2
Rubinstien-Taybi Syndrome	759.89	Q87.2
Sandhoff Disease	330.1	E75.01
Sanfillippo Syndrome	277.5	E76.22
Schindler Disease Type 1	271.8	E77.1
Schizencephaly	742.4	Q04.6
Seckel Syndrome	759.89	Q87.1
Septo-optic Dysplasia	742.4	Q04.4
Severe Hypoxic Ischemis CNS Injury	768.73	P91.63
Severe Intellectual Disability	318.1	F72
Sjogren-Larsson Syndrome	757.1	Q80.9
Spastic Hemiplegia	342.1	G80.2
Spielmeyer-Vogt Disease	330.1	330.1 E75.4

Spina Bifida	741	Q05
Spina Bifida without mention of Hydrocephalus	741.9	Q05.8
Spinal Cord Injury (Initial Encounter)	952.9	S14.109A
Spinal Muscular Atrophy, Unspecified	335.1	G12.1
Sturge-Weber Syndrome	759.6	Q85.8
Symptomatic Torsion Dystonia (Athetoid Cerebral Palsy)	333.7	G80.3
Tay-Sachs Disease	330.1	E75.02
Torch Syndrome	760.02	P00.2
Trisomy 13	758.1	Q91.13
Trisomy 18 (Edwards' Syndrome)	758.2	Q91.3
Tuberous Sclerosis	759.5	Q85.1
Unspecified (Traumatic Blindness NOS)	950.9	S04.019A
Unspecified Anomaly of Brain, Spinal Cord and Nervous System	742.9	Q07.9
Unspecified Cause of Encephalitis	323.9	G04.90
Unspecified Delay in Development (Developmental Disorder NOS)	315.9	F89
Unspecified Disease of Spinal Cord	336.9	G95.9
Unspecified Intellectual Disability	319	F79
Unspecified Pervasive Developmental Disorder (Pervasive Developmental Disorder NOS)	299.9	F84.9
Untreated Phenylketonuria	270.1	270.1
Urea Cycle Defects	270.6	E72.20
Usher Syndrome Type II	694.4	L10.4
Vater Association	759.89	Q87.2
Werdnig-Hoffman	335.0	G12.0
Williams-Beauren Syndrome	758.9	Q87.8
Wilson Disease	275.1	E83.01
Zellwager Syndrome	277.86	E71.510
Psychiatric Disorder or Problem		F99

Description of diagnosis related to disability: _____

_____

_____

_____

My signature on this document certifies that the diagnosis identified is based on medical evaluation and documentation and/or established medical evaluation and documentation.

Physician's Name: _____

License Number: _____

Address: _____

Telephone Number: _____

Physician’s Signature: _____

Date: _____