# On Our Own

Dear Applicant,

Thank you for inquiring about On Our Own, Inc. First Step, Inc. is a private, nonprofit organization that provides supervised living and training for adults who are developmentally disabled. Our offices are located at 101 Alcorn St. and 407 Carson St. in Hot Springs, AR.

Our two group homes in Hot Springs, AR have been in operation since April 1, 1986. We also have apartment complexes located in Hot Springs, Malvern, and Fordyce. We are able to provide housing for 106 adults with developmental disabilities.

**All applicants must be 18 years or older and submit the following:**

1. Completed and signed application
2. Completed On Our Own Social History
3. Psychological/ Intellectual Functioning report
4. (Current within the past 5 years)
5. High School Diploma or letter of completion, if applicable
6. Copy of Guardianship papers, if applicable
7. Copy of Identification Card or Driver's License
8. Copy of Birth Certificate *
9. Copy of Social Security Card *
10. Copy of Medicaid Card (if applicable)
11. Copy of Medicare Card (If applicable)
12. Copy of private insurance card (if applicable)
13. Copy of PASSE ID Card
14. Contact Info for PASSE Care Coordinator
15. Copy of Optum Assessment
16. A current physical assessment form Completed by PCP
17. Documentation of hospitalization (inpatient, outpatient, mental health, etc.) within the past year.
18. Proof of Income (SSI Letter and/or last 6 check stubs from employer)
19. Information regarding the student status of all applicant household members, if applicable
20. Identification of any applicant household member that is a veteran, if applicable
21. Whether the family is seeking housing due to a Presidentially Declared Disaster, if applicable
22. Custody arrangement of any children (full, joint, etc.) in the household, if applicable

*** Please refer to list of other exceptions to disclosure of SSN.**

**Must have all these documents prior to move in.**

Once the application has been submitted and it is determined that you are eligible, you will be placed on our waiting list according to the date we received your application.

If you have any questions, please contact the HUD Coordinator at (501)-620-5502.

Sincerely,

Angela Logue
HUD Coordinator

Please return documents to:

Attn: Angela Logue
First Step, Inc. / On Our Own, Inc.
P.O. Box 2440
Hot Springs, AR 71914

Fax: (501)-620-4676
Email: Angela.Logue@FStep.org

# On Our Own

**Exceptions to Disclosure of Social Security Number:**

The following verifications may also be used to prove age:

- Baptismal Certificate
- Military discharge papers
- Valid passport
- Census Document showing age
- Naturalization Certificate
- Social Security Administration Benefits printout

The following documents are acceptable as verification of social security number:

- Original Social Security Card
- Original document issued by a federal or state government agency which contains the name, SSN, and other identifying information of the individual
- Driver's license with SSN
- Identification card issued by a medical insurance provider, or by an employer or trade union
- Earnings statements on payroll stubs
- Bank Statement
- Form 1099
- Benefit award letter
- Retirement benefit letter
- Life insurance policy
- Court Records

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501.624.6468

EQUAL HOUSING OPPORTUNITY

OMB Control # 2502-0581
Exp. (02/28/2019)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

**SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING**

This form is to be provided to each applicant for federally assisted housing

**Instructions: Optional Contact Person or Organization**: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

| | |
|---|---|
| **Applicant Name:** | |
| **Mailing Address:** | |
| **Telephone No:** | **Cell Phone No:** |
| **Name of Additional Contact Person or Organization:** | |
| **Address:** | |
| **Telephone No:** | **Cell Phone No:** |
| **E-Mail Address (if applicable):** | |
| **Relationship to Applicant:** | |

**Reason for Contact:** (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

**Commitment of Housing Authority or Owner:** If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

**Confidentiality Statement:** The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

**Legal Notification:** Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization.B y accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ Check this box if you choose not to provide the contact information.

| | |
|---|---|
| | |

**Signature of Applicant** **Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

**Privacy Statement:** Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.

FIRST STEP

On Our Own

## APPLICATION FOR SERVICE

Applicant Name: _____
First Last Social Security No. Date of Birth Race

List all other members of applicant's household

First Last Social Security No. Date of Birth Race

1. _____
2. _____

Is the applicant, or any member of the applicant's household, subject to State lifetime sex offender registration in any state? Yes____ No____

Applicant's Phone: _____ Sex: Male ____ Female _____ Decline to Disclose ___

Address: _____
Street City State/Zip Code

Marital Status: Single____ Married____ Divorced____ Separated____ Widow____ Decline to Disclose___

Legal Status: Is the applicant their own guardian? Yes_____No_____
If no, has he/she been declared incompetent by a court of law? If so, please include a copy of the guardianship papers.
If the applicant has a guardian, who is it? _____

Primary Language _____ Religious Preference_____

In case of an emergency, who should be contacted?
Name_____ Relationship_____
Address_____ Phone_____

Third Party Insurance Benefits:
Medicaid Number _____ In what name? _____
Medicare Number _____ In what name? _____
Insurance Company _____ Type of Insurance _____

**For Agency Use Only:**
Date Application Received _____ Time Received_____
Received by_____
Admission-Project _____ Date_____

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501.624.6468

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Education (List Schools Attended)

School Address Dates Attended

_____

_____

_____

Job/Placement Experience

Does the applicant have a job at this time? Yes_____ No_____
If yes, please list where: _____
Place of Employment Address Phone

Supervisor_____ Length of Employment_____

If the applicant is not presently employed, have they been employed in the past? Yes_____ No_____
Please give employment history:

Place of employment Address/Phone Supervisor Duties Dates employed

_____

_____

_____

What kind of job does applicant like/dislike? _____

Please list where the applicant and members of household, have previously resided (including all other states):
Where Address Dates

_____

_____

_____

Was the applicant 62 or older as of 1/31/2010 and did not have a SSN, and receiving HUD rental assistance at another location on 1/31/2010? Yes____ No____

Human Service History (Please List Services Applicant Has Utilized)

| Services | Address | Dates Used |
|---|---|---|
| *Social Services | | |
| *Rehab Services | | |
| *Mental Health Center | | |
| *Day Service Center | | |
| *Sheltered Workshop | | |
| *State Institution | | |
| *Nursing Home | | |
| *Other | | |

Please provide information on the following sources of income:

| Source | Amount Received | In Whose Name | How Often |
|---|---|---|---|
| *SSI | | | |
| *Social Security | | | |
| *Employment Wages | | | |
| *VA Benefits | | | |
| *Retirement Benefits | | | |
| *Trust Fund | | | |
| *EBT | | | |
| *Other | | | |

Does the applicant have a checking account Yes_____ No_____

Name of Bank Address Name on account

Does the applicant have a savings account? Yes_____ No_____

Name of Bank Address Name on account

**DISABILITY DIAGNOSIS {PLEASE CHECK ALL THAT APPLY TO APPLICANT}**

Intellectual Disability/ Developmental Disability _____Cerebral Palsy _____Epilepsy _____Autism_____

Down Syndrome_____ Other: _____

Please provide the following information in regard to disability:

Age of onset of disability: _____
Is disability: Improving _____ Getting worse _____ Stable _____

If epileptic, please describe frequency of seizures, date of last seizure, medication (with dosage) and name of neurologist/doctor: _____
_____
_____
_____
_____

Does the applicant undergo any routine treatment for the disability or related condition?
YES: _____ NO: _____

If yes, please describe where he/she gets treatment, what the treatment consists of, doctor, medication and any other pertinent information: _____
_____
_____
_____
_____

Please describe any secondary disabling condition:
_____
_____
_____

When was the applicant last seen by any medical personnel?
{Includes primary care physician, dentist, or any specialist}

| DATE | DOCTOR | ADDRESS/PHONE | REASON FOR VISIT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list the applicant's doctor who is most familiar with their disability and would be able to verify their disability:

_____

Doctor Name Complete Address Phone number

Please describe applicant's ability in the following areas {use back of page, if necessary}

ACTIVITY GOOD FAIR POOR NO

*Walking: _____
*Speech: _____
*Eyesight: _____
*Hearing: _____
*General Health: _____

Does the applicant use any of the following special equipment?

*Glasses YES: _____ NO: _____
*Hearing Aid YES: _____ NO: _____
*Braces (limb) YES: _____ NO: _____ EXPLAIN: _____
*Wheelchair YES: _____ NO: _____
*Other (please list) YES:_____ NO: _____ EXPLAIN: _____

FAMILY:

List all members in immediate family and/or significant others: {use back of page if necessary}

NAME ADDRESS/PHONE RELATIONSHIP

_____

_____

_____

_____

Describe the applicant's relationship/interaction with the family:

_____

_____

**General Information**:

Please answer the following to the best of your ability {use back of page for further explanations, comments, etc.}

Is applicant currently under a physician's care for any ailment? YES: _____ NO: _____

If yes, please describe {ailment, doctor, medication etc.}

_____

_____

_____

_____

List all medications taken by applicant: {give name and dosage}: _____

_____

_____

_____

_____

Does the applicant have any allergies? YES: _____ NO: _____

If yes, please list allergies and treatment: _____

_____

_____

Has the applicant received therapy? {Psychological, physical, speech, occupational}:

YES: _____ NO: _____

If yes, please describe. {Give dates, who provided therapy, etc.}: _____

_____

_____

_____

**General Information Continued:**

Please describe how the applicant responds when he/she is:

Angry: _____

Afraid: _____

Depressed: _____

Sad: _____

Upset: _____

Nervous: _____

How does the applicant respond to authority figures? _____

_____

What kind of activities does the applicant most enjoy? _____

_____

List applicant's hobbies or special interest: _____

_____

Person filling out the application: _____
Name Relationship

*As part of this application for services, I hereby authorize the release and/or exchange of professional information on behalf of this applicant between On Our Own and a public and/or private professional agency and/or individual having professional contact with the applicant and/or his/her family.*

_____ _____
Signature of applicant or guardian, if applicable Date

_____ _____
Signature of witness, if applicable Date

*Thank you for taking time to fill out this application. If you have any questions, please call 501-620-5432.*
*You have the right to reasonable accommodations during the application process*

PENALTIES FOR MISUSING THIS CONTENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a) (6), (7) and (8).

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FIRST STEP

On Our Own

SOCIAL HISTORY QUESTIONNAIRE

Applicants Name _____

Age: _____ Date of Birth: _____ Sex: Male ____ Female _____ Decline to Disclose ___

Person Completing Form: _____

Relationship to Applicant: _____

Referral Information:

Where does the applicant presently live? _____

_____

What problems does the applicant have in their present situation? _____

_____

What is the reason you contacted On Our Own? _____

_____

How did you hear about us? _____

_____

Is the applicant in school, training program, or work? _____

_____

What assistance do you feel the applicant needs? Why? _____

_____

Do you feel the applicant needs a different place to live? Why? _____

_____

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PRESENT CONDITION OF APPLICANT

1. Primary Disabilities (Check appropriate blank & all that apply)

   Intellectual Disability/ Developmental Disability _____
   Functional Level (if known) _____
   Epilepsy _____
   Seizures (Type & Frequency) _____
   Cerebral Palsy _____
   Functional Level (if known) _____
   Autism _____
   Functional Level _____
   Down Syndrome _____
   Functional Level _____

2. Other Disabilities

   Physical Yes ___No ___
   Describe _____

   Mental Yes ___ No ___
   Describe _____

3. Describe applicant's general health with regard to:
   Diseases _____
   _____

   Infections _____
   _____

   Allergies _____
   _____

   Special Diet needs (if any) _____
   _____

   Medications taken (name & dosage) _____
   _____
   _____

   Other health concerns or needs not previously addressed _____
   _____

Describe applicant's ability to: (Indicate any assistance needed)

Walk _____

Talk _____

See _____

Hear _____

Feed Self _____

Dress Self _____

Use Toilet _____

Bathe/Groom Self _____

Read _____

Write/Print _____

Tell Time _____

Recognize money/make change _____

Use telephone _____

Wash clothes _____

Prepare own meals _____

Travel alone _____

Work independently _____

**Behavior Description**

Does the applicant have behavior problems? Yes _____ No_____

If yes, list all of them & how they are exhibited (includes hurting self/others, aggression, destruction of property, etc.)

_____

_____

_____

_____

_____

_____

Describe applicant's special interest, abilities, hobbies, and/or recreational activities:

_____

_____

_____

**Developmental/Family History**

Where was the applicant born? _____

_____

Were there any medical problems before, during, or after birth? _____

_____

_____

When the primary disability was first noticed? _____

_____

When did any other disabilities occur? _____

_____

_____

Indicate any physical, psychological, and/or learning disabilities of other family members: _____

_____

_____

_____

How does the family get along? _____

_____

_____

How has the family adjusted to the applicant's disability? _____

_____

_____

_____

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FIRST STEP

On Our Own

## CRIMINAL AND SEX OFFENDER BACKGROUND CHECK

Federal law requires drug, criminal, and sex offender registration information about each household member, 18 years and older, applying for assisted housing. This complete and signed form gives consent to On Our Own, Inc. to run a background check. Every applicant, 18 years and older, must complete and sign this form in order to be considered for assisted housing with On Our Own, Inc. Applications from anyone who refuses to sign this form will be denied by On Our Own, Inc.

Please answer the following questions:

1. Have you ever been evicted from a federally assisted site for drug-related criminal activity within the past three (3) years? Yes____ No____
2. Do you currently use illegal drugs and/or abuse alcohol? Yes____ No____
3. Are you currently subject to a lifetime registration requirement under a state sex offender registration program? Yes____ No____
4. Have you ever been convicted of any drug-related crime within the past five (5) years? Yes___ No___
5. Have you been convicted of any felony within the past five (5) years? Yes____ No____
6. Have you been convicted of any crime involving fraud or dishonesty within the past five (5) years? Yes___ No__
7. Have you been convicted of any crime involving violence within the past five (5) years? Yes___ No___
8. Are you currently charged with any of the above criminal activities? Yes____ No____
9. Have you ever used or been known by any other names? Yes____ No____

   If yes, please list each name used:

_____

_____

_____

_____



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Please check all states in which you have lived or have held licenses to drive (include all license numbers):

_____

_____

_____

**I understand that the above information is required to determine my eligibility for residency. I certify that my answers to the above questions are true and complete to the best of my knowledge. I understand that making false statements on this form is grounds for rejection or termination of my lease. I authorize On Our Own, Inc. to verify the above information and I consent to the release of necessary information to determine my eligibility.**

**RELEASE: I hereby authorize law enforcement agencies to release criminal records and/or sex offender registration information to On Our Own, Inc., to a Public Housing Authority, or to an agency contracted by On Our Own, Inc., to conduct criminal background checks.**

_____ _____

Applicant's Printed Name Date

_____ _____

Applicant's Signature Date

PENALTIES FOR MISUSING THIS CONTENT:

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EQUAL HOUSING OPPORTUNITY

**We Do Business in Accordance With the Federal Fair Housing Law**

(The Fair Housing Amendments Act of 1988)

# DISCLOSURE AND AUTHORIZATION FOR CONSUMER REPORTS

In connection with my application to rent a dwelling with First Step, Inc., further known as ("Company"). I understand consumer reports will be requested by ACUTRAQ Background Screening. These reports may include, as allowed by law, the following types of information, as applicable: names and dates of current and previous employers, reason for termination of employment, work experience, names and dates of current and previous tenancy, reasons for termination of tenancy, credit, etc. I further understand that such reports may contain public record information such as, but not limited to: judgments, bankruptcy proceedings, evictions, criminal records, etc., from federal, state, and other agencies that maintain such records.

In addition, investigative consumer reports (gathered from personal interviews, as applicable, with current and former employers and/or landlords, past or current neighbors and associates of mine, etc.) to gather information regarding my work or tenant performance, character, general reputation and personal characteristics, and mode of living (lifestyle) may be obtained.

I understand that the Company can use this disclosure and authorization to continue to obtain such consumer reports throughout my lease period.

**Authorization**

**I hereby authorize procurement of consumer report(s) and/or investigative consumer report(s) by Company. This authorization shall remain on file and shall serve as ongoing authorization for the Company to procure such reports at any time during my lease period. I authorize without, reservation, any person, business or agency contacted by ACUTRAQ Background Screening, to furnish the above-mentioned information.**

**Summary of Rights: This authorization is conditioned upon the following representations of my rights:**
I understand that I have the right to make a request to the consumer reporting agency: ACUTRAQ Background Screeing , P.O. Box 766 Elkins, Arkansas, 479-439-9174 , upon proper identification, to obtain copies of any reports furnished to the Company by ACUTRAQ Background Screening and to request the nature and substance of **all information** in its files on me at the time of my request, including the sources of information, and ACUTRAQ Background Screening, on Company's behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by any investigative consumer report(s). ACUTRAQ Background Screening will also disclose the recipients of any such reports on me which the ACUTRAQ Background Screening has previously furnished within one year preceding my request (California three years). I hereby consent to Company obtaining the above information from the ACUTRAQ Background Screening. I understand that I can dispute, at any time, any information that is inaccurate in any type of report with the ACUTRAQ Background Screening. I may view the ACUTRAQ Background Screening's privacy policy at their website: www.ACUTRAQ.com

I understand that if the Company is located in California, Minnesota or Oklahoma, that I have the right to request a copy of any report Company receives on me at the time the report is provided to Company. By checking the following box, I request a copy of all such reports be sent to me. Check here: ☐

In connection with my application for rental, I direct the following regarding my current employer and/or landlord: (please check one).

_____ Yes, my current employer may be contacted
_____ No, my current employer cannot be contacted
_____ Yes, my current and previous landlord may be contacted
_____ No, my current nor previous landlord may be contacted

I understand that I have rights under the Fair Credit Reporting Act, and I acknowledge receipt of the Summary of Rights _____ (initials).

Printed Name: _____

Signature: _____

Social Security No.: _____; Date of Birth: _____

# On Our Own
## Risk Assessment

INDIVIDUAL NAME _____

*Note: If health and/or safety issues are identified, it is the responsibility of providers to analyze what supports are available and can be put in place that will assure health and safety. Identified objectives are also to be considered when identifying health and safety supports. A positive response to any item (other than "No Occurrences") must assure there is a support that can address the issue(s) to help prevent occurrence or deal with the issue if it occurs.*

1) Indicate individual's residential setting: ☐ Lives alone ☐ Lives with others

Notes: _____

2) Does the individual have a routine voluntary caregiver(s)?: ☐ Yes ☐ No

Notes: _____

*Note: If the individual lives alone and has no routine voluntary caregiver, the plan must identify how health and safety is assured in the absence of a paid or non-paid caregiver.*

3) Indicate whether the individual presently requires direct support staff be trained in special health care procedures (e.g., ostomy care, positioning, certain adaptive devices, etc.).

☐ Yes ☐ No

4) Select the response that best describes the individual's wheelchair mobility. If the individual does not use a wheelchair, please indicate.

☐ Individual does not use a wheelchair
☐ Can use a wheelchair independently, including transferring
☐ Can use a wheelchair independently with assistance in transferring
☐ Requires assistance in transferring and moving
☐ No mobility (must be transferred and moved)

*Note: If the individual uses a wheelchair and requires assistance in transferring and/or moving, or is not mobile, the provider must ensure that the individual can be evacuated from their residence in case of emergency. Examples of possible assurances are 1) the presence of personal emergency response systems and/or 2) voluntary caregivers. For some individuals, a personal emergency response system may adequately address the safety issues. The provider must address how the individual is to be evacuated from their residence in case of emergency.*

5) Select all responses that best describe the individual's ability to manage medications.

- ☐ Individual requires medications to be prepared by filling weekly medication box by staff.
- ☐ Individual requires daily reminders to take medication.
- ☐ Individual requires monitoring the intake of medications.
- ☐ Individual does not require assistance with medication management

List all medications taken by applicant: {give name and dosage}:

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

6) Indicate the frequency of each behavior over the last twelve months:

**Legend**

| | |
|---|---|
| **No Occurrences** | **Behavior not displayed** |
| **Occasionally** | **Less than once per month** |
| **Monthly** | **About once per month** |
| **Weekly** | **About once per week** |
| **Frequently** | **Several times per week** |
| **Daily** | **Once a day or more** |

**Runs or wanders away**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Eats inedible objects**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Displays behavior of a sexually offending or predatory nature**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Displays (engages in) behavior of an aggressive or destructive nature (to include self-abuse)**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Individual intentionally or unintentionally does not follow rules about electricity, fire, water, tools, traffic, interacting with strangers, or hazardous physical situations like broken windows or open trenches.**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Individual intentionally or unintentionally threatens to do harm to self, others or objects.**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

**Uses addictive substances (specify the substance(s)**

☐ No Occurrences ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Frequently ☐ Daily

Case Manager Notes:

Signature of Case Manager/Center Director Date

Signature of Consumer/Guardian Date

The signature above attests the information contained is, to the best of their ability, an accurate representation of the assessed individual's risk issues. It does not necessarily indicate agreement on family involvement.

# Primary Care Physician Completes the Following Forms

FIRST STEP

On Our Own

## VERIFICATION OF DISABILITY

DATE:

TO:

FROM: On Our Own, Inc.
ATTN: Angela Logue
P.O. Box 2440
Hot Springs, AR 71914
FAX: (501)620-5436

**RETURN THIS VERIFICATION TO THE PERSON LISTED ABOVE**

SUBJECT: Verification of Disability

Name: _____

Address: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing owner to verify all information that is used in determining this person's eligibility or level of benefits.

We ask for your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help ensure timely processing of the application for assistance. Enclosed is a self-addressed, stamped envelope for this purpose. The applicant/tenant has consented to the release of this information as shown on page 3 or the attached for HUD-9887.

1. Yes____ No____ Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

2. Yes____ No____ Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C 6001(8)), i.e., a person with a sever chronic disability that:
   a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   b. Is manifested before the person attains age 22;
   c. Is like to continue indefinitely
   d. Results in substantial functional limitation in three or more of the following areas of major life activity;
      1) Self-care
      2) Receptive and expressive language
      3) Learning
      4) Mobility
      5) Self-direction
      6) Capacity for independent living, and
      7) Economic self-sufficiency; and
   e. Reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

3. Yes____ No____ Is a person with a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

4. Yes____ No____ Is a person whose sole impairment is alcoholism or drug addiction.

_____ _____

NAME AND TITLE OF PERSON SUPPLYING THE INFORMATION

FIRM/ORGANIZATION

_____ _____

SIGNATURE

DATE

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature _____ Date _____

Note to Applicant/Tenant: You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employees of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretense concerning an applicant or participant, may be subjected to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the office or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 208 (a) (6), (7), and (8). Violations of these provisions are cited as violations of 42 USC 408 (a) (6), (7), and (8).


**We Do Business in Accordance With the Federal Fair Housing Law**
(The Fair Housing Amendments Act of 1988)

FIRST STEP
P.O. Box 2440
Hot Springs, AR
71914-2440 Clasp 5

This page to be filled out and signed by a physician

Name: Date of Birth:

General Appearance: _____

Height: _____ Wight: _____ Pulse: _____ Temp: _____ BP: _____

Check "Normal" findings with "O". Check "Abnormal" findings with an "X". Describe abnormal findings in the space at the right.

1. _____ Head
2. _____ Eyes (including vision as best can be determined-eye chart used)
3. _____ Ears (including hearing as best can be determined-whisper voice to 10 ft.)
4. _____ Nose/Throat
5. _____ Teeth/Mouth
6. _____ Neck
7. _____ Chest/Lungs
8. _____ Breasts
9. _____ Heart
10. _____ Abdomen
11. _____ Genitals/Rectum
12. _____ Pap smear
13. _____ Back, bones, joints, extremities
14. _____ Skin, lymphatics, hair
15. _____ Musculature
16. _____ Nutrition

NEUROLOGICAL

17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. Physical Therapy _____

Diet _____

Allergies _____

Medications _____

_____

Diagnosis/Impressions: _____

_____

Recommendations: _____

_____

_____

Physician's Signature

_____

Examination Date

**AUTHORIZATION TO DISCLOSE**
**PROTECTED HEALTH INFORMATION (PHI)**

**Name:**

**DOB:**

**SSN:**

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, PASSE or other health care provider that has provided payment, treatment, or services to me or on my behalf to disclose certain protected health information about me to First Step, Inc.

Specifically, this authorization permits you to disclose the following protected health information about me to First Step, Inc.:

> **ALL RECORDS- This includes your entire file, including but not limited to histories, physicals, evaluations, diagnoses, progress notes, correspondence, billings, reports, lab results, orders from physicians and others, x-rays (only if specifically requested), and records received from other providers, etc.**

This authorization also permits you to discuss with First Step, Inc. all such health information about me as described above. This authorization does not authorize you to author any original report, or engage in any verbal communications with anyone except First Step, Inc.

I understand that if my record contains information pertaining to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, or psychiatric or psychological conditions, that this authorization includes that information.

The information is being disclosed at my request for the purpose of coordination of services by First Step, Inc.

**I authorize the use of a telefax or photocopy of this form for the disclosure of the information described above.**

**I understand that I may revoke this authorization to disclose information at any time to the extent that action has been taken in reliance on it, and that in any event this consent expires within 1 year from the date signed.**

**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 or my eligibility for benefits.**

**THIS AUTHORIZATION IS VALID BASED ON THE SIGNATURE BELOW AS PROVIDED BY LAW:**

**Name of Individual**

**Name of Legal Guardian, if applicable**

**Signature of Individual or Legal Guardian**

**Date Signed**

Name of consumer/patient:_____
Medicaid number:_____DOB:_____
Physician's name:_____

Dear Doctor:
According to the **Nurse Practice Act**, some nursing task(s) may be delegated to unlicensed persons. The act requires an RN to periodically review all training and processes. We are suggesting the following task(s) be considered for delegation to unlicensed staff:

_____Medication assistance **{which excludes licensed nursing duties}**

_____Oxygen therapy to include room set up and flow rate

_____Ostomy care

_____Sterile dressing change

_____Urinary catheterization {flushing only}

_____Other_____

---

**PHYSICIAN AUTHORIZATION:**
I have examined this patient and I believe that using the provisions of the **Nurse Practice Act** including those provisions requiring training and consultation with an RN, can be safely delegated to the First Step direct support professional staff.

_____ _____
Signature of attending physician Date

*complete act may be viewed @ ACA §17-87-101

Rev. 3/9/2023