



# Genesee Valley Improvement Corporation

*An ACCORD Corporation Subsidiary Company*

84 Schuyler Street, P.O. Box 157 | Belmont, NY 14813

Telephone (585) 268-7605 | Fax (585) 449-0292

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## GVIC and Kalthoff House Rentals

To whom it may concern:

Thank you for your interest in applying for a rental unit within GVIC/Kalthoff House. **Please be sure that you complete all questions and fill in all blanks for everyone in your household on all the attached pages.** Incomplete applications will not be accepted and will be returned to you for completion.

Once you return the attached pages, we will let you know if we have a unit available now, if you have been placed on the waitlist or if you are ineligible for the unit. If you are eligible and we have a unit available, you will be scheduled for an interview.

Please note that all GVIC/Kalthoff House apartments are smoke and pet free.

If you have any questions please feel free to contact our Housing Counselor at (585) 268-7605, ext. 1119. Thank you for your interest and cooperation in filling out the pre-application.

Sincerely,

ACCORD's Housing Counselor

# GVIC Preliminary Rental Application

Please note that if this application is not complete it will not be accepted. There are 5 pages  
**Circle Preferred Location: Cuba Belmont Belfast Friendship Almond**

Applicant Information			
Name:			
Date of birth:		Phone:	
Current address:			
City:	State:	ZIP Code:	
(Please circle) Own    Rent    Homeless    Imminent Homeless		Monthly payment or rent:	How long?
Previous address:			
City:	State:	ZIP Code:	
Owned    Rented    (Please circle)		Monthly payment or rent:	How long?
Employment Information			
Current employer:			
Employer address:			How long?
Phone:	E-mail:	Fax:	
City:	State:	ZIP Code:	
Position:	Hourly    Salary    (Please circle)	Annual income:	
Previous Assistance from ACCORD			
Have you or a household member ever received rental assistance through an ACCORD program? Yes or No			
If you or a household member has received assistance before from ACCORD did you leave the program in good standing? Or were you terminated? Please explain			
Co-applicant Information			
Name:			
Date of birth:		Phone:	
Previous address:			
City:	State:	ZIP Code:	
Owned    Rented    (Please circle)		Monthly payment or rent:	How long?
Co-applicant Employment Information			
Current employer:			
Employer address:			How long?
Phone:	E-mail:	Fax:	
City:	State:	ZIP Code:	
Position:	Hourly    Salary    (Please circle)	Annual income:	
References-Must be previous Landlord or Credit references (These may NOT be relatives)			
Name:	Address:	Phone:	
Arrest/Conviction Information			
Have you or a household member ever been arrested for, convicted of or awaiting trial for any of the following: Please indicate yes or no for each			
a. _____	Sexual Abuse/Assault		
b. _____	Drug Related Crime		
c. _____	Violent Criminal Behavior		
Signature of applicant:			Date:
Signature of co-applicant:			Date:

**Return to: ACCORD, Attn: Housing Department, P.O. Box 573, Belmont, NY 14813**

ACCORD Corporation

04/07/17 ee

Homelessness Application

Date: \_\_\_\_\_ Application Profile For: \_\_\_\_\_

- Housing Status: (check all that apply)**
- Currently in emergency shelter
  - Currently in hotel/motel
  - Currently in transitional facility
  - Currently residence condemned/dangerous
  - Family violence
  - Documented history of frequent evictions
  - Temporarily doubled up in other person's residence
  - Family has been separated legally/physically; may now be unified
  - Unable to live independently without supportive services
  - Transient/living on the street
  - Other: \_\_\_\_\_

To be completed by Referral Source: \_\_\_\_\_  
Referral Staff Name and Title (please include contact number)

- Applicant(s) would benefit from supportive housing because:**
- Homeless
  - At-risk of becoming homeless
  - Can't afford market rent
  - Current apartment is substandard
  - Frequent moves
  - Overcrowded
  - Physically handicapped
  - Other disability\*: \_\_\_\_\_
  - Would benefit from support environment
  - Other: \_\_\_\_\_

\*This may include various mental disabilities and/or substance abuse

Referral Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

**Application Decision: (to be completed by Homeless Prevention Specialist)**

- Approved       Denied
- (if Denied) For the following reasons:**
- Income ineligible
  - Not homeless per HHAP regulation
  - Inappropriate facility
  - Unfavorable rental history
  - Unfavorable character references/active substance abuse/violence

Homeless Prevention Specialist's Signature \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_

Head of Household Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Heating Source: \_\_\_\_\_ Housing:  Own  Rent  Other \_\_\_\_\_ Family Size: \_\_\_\_\_ Email: \_\_\_\_\_  
 Family Type (Please check the type that best fits your household):  
 Single Parent / Female  Single Parent / Male  Single Person  Two Parent Household  
 Two or More Adults (No Children)  Grandparents Raising Child  Mixed Adults with Children  Extended Family Household  
 Other: \_\_\_\_\_

	Head of Household (HOH)	Household Member #2	Household Member #3	Household Member #4
Full Name:				
Date of Birth:				
Social Security Number:				
Medical Coverage If Yes, what Carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnicity				
Primary Language				
Marital Status				
Level of Education				
Employment				
Job Type				
Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to HOH				
Income (Monthly)	\$ _____	\$ _____	\$ _____	\$ _____
Driver's License	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Stamps (SNAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Automobile	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**OFFICE USE ONLY**  
 Inc.: \_\_\_\_\_ AMI: \_\_\_\_\_ % Cap60: \_\_\_\_\_ Budget:  Hours Completed: \_\_\_\_\_ /12 hrs. Certificate:

Referrals Made To: \_\_\_\_\_  
 I certify that the above information is true and accurate to the best of my knowledge. I understand that by signing this application, I am entitled to all ACCORD programs and services that I may be eligible for. Information on this application may be provided to other programs and services administered by ACCORD.  
 Head of Household Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 ACCORD Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# ACCORD

Allegany County Community Opportunities and Rural Development, Inc.  
*Helping People. Changing Lives. Since 1972.*

Community Action Agency • Rural Preservation Company

## Authorization to Release Criminal Information for Housing Unit Rental Purposes

The housing unit for which I am applying to rent requires me to consent to a criminal background check as a rental condition. This check includes the following: Criminal history reference searches for felony and misdemeanor convictions at the county and federal levels of every jurisdiction where I currently reside or where I have resided during the past five (5) years; and sex offender registry searches at the county and federal levels in every jurisdiction where I currently reside or where I have resided.

Date: \_\_\_\_\_

I, \_\_\_\_\_

Full Legal Name: First, Middle, Last

hereby authorize ACCORD to conduct the criminal background check described above. In connection with this, I also authorize the use of law enforcement agencies and/or private background check organizations to assist ACCORD in collecting this information.

I also am aware that records of arrests on pending charges and/or convictions are not an absolute barrier to renting a housing unit. Such information will be used to determine whether the results of the background check reasonably bear on my trustworthiness or my ability to meet the eligibility requirements.

Other Names I've Used in Past 5 Years:

Current Address: \_\_\_\_\_

Previous Address (Most Recent): \_\_\_\_\_

Addresses in the 5 years prior to completing this authorization (Use reverse side if needed):

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# ACCORD

*Allegany County Community Opportunities and Rural Development, Inc.*

## Authorization to Release and/or Obtain Information

The program participant, or his/her personal representative, may voluntarily complete this *Authorization to Release or Obtain Information* granting permission to ACCORD to use, disclose, and/or obtain confidential, personal, and/or private information pertaining to the program participant such as personal health information and personally identifiable information. ACCORD prohibits the use, disclosure, and obtaining of confidential, personal, and/or private program participant information without the consent of the program participant or his/her personal representative, except in circumstances described in the attached *Disclosure without Consent Notice*.

### Definitions

*Personally Identifiable Information (PII)* is information that could identify a specific individual, including but not limited to an individual's name, name of an individual's family member, street address of the individual, social security number, telephone number, date and/or place of birth, mother's maiden name, or other information that is linkable to the individual.

*Personal Health Information (PHI)*, also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that a healthcare professional collects to identify an individual to determine appropriate care.

Program Participant Name (Print): \_\_\_\_\_

### Authorization to Release and/or Obtain Information

I, (print name) \_\_\_\_\_

authorize the release of the following information:

*Description of the information to be used/disclosed/obtained (specify documents, records, etc. if applicable):*

to / from:

*Identify the party or class of parties that the participant is authorizing the information described above to be disclosed to and/or obtained from: (If known, include the name[s] of the agency[ies], addresses, name[s] of the person[s], and/or the job title[s] of the person[s].)*

for the purpose of:

*Explain why the information will be disclosed:*

**Authorization to Release and/or Obtain Information** (continued from Page 1)

I hereby authorize the use, disclosure and/or obtainment of the information described on page one (1) of this form to and/or from the person(s) and/or class of parties identified on page one (1) of this form. I understand that:

1. Only this information may be used, disclosed and/or obtained as a result of this authorization.
2. This information is confidential and cannot be legally disclosed without my permission.
3. If this information is disclosed to a person, persons, and/or class of parties who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke this authorization at any time. I am aware that my revocation will not be effective if the person(s) and/or class of parties I have authorized to receive this information has/have already taken action as a result of this authorization.
5. I do not have to complete or sign this authorization and my refusal to complete or sign this authorization will not affect my eligibility or ability to obtain and/or participate in programs and/or services provided by ACCORD.
6. I have the right to inspect and copy my own records and personal health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations.

Select one of the following use/disclosure options:

**One Time Use/Disclosure:**

I hereby authorize the one-time use, disclosure, and/or obtainment of the information described on page one (1) of this form to and/or from the person(s) and/or class of parties identified on page one (1) of this form. My authorization will expire:

- When acted upon;
- 90 days from the date of my signature on this form; or
- Other: \_\_\_\_\_

**Periodic Use/Disclosure:**

I hereby authorize the periodic use, disclosure, and/or obtainment of the information described on page one (1) of this form to and/or from the person(s) and/or class of parties identified on page one (1) of this form as often as necessary to fulfill the purpose explained on page one (1) of this form.

My authorization will expire:

- When I am no longer receiving services and/or participating in programs provided by ACCORD;
- One (1) year from the date of my signature on this form; or
- Other: \_\_\_\_\_

**Program Participant Signature:**

I hereby certify that I authorize the used, disclosure, and/or obtainment of my information as set forth in this document.

\_\_\_\_\_  
 Program Participant / Personal Representative Signature Date  
 Description of Personal Representative's authority to act for the program participant:

**Witness Statement and Signature:**

I have witnessed the execution of this authorization and hereby verify that a copy of this signed authorization was provided to the program participant and/or the participant's personal representative.

\_\_\_\_\_  
 Staff Person's Name and Job Title



# ACCORD

*Allegany County Community Opportunities and Rural Development, Inc.*

## Refusal and/or Revocation of Authorization to Release and/or Obtain Information

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Program Participant Name (Print): \_\_\_\_\_

I hereby (select one):

- refuse to authorize the use, disclosure, and/or obtainment of my confidential, personal, and/or private information.
- revoke my authorization to use, disclose, and/or obtain the information described on page one (1) of this form to and/or from the person(s) and/or class of parties identified on page one (1) of this form. I understand that my revocation of this authorization will not have any effect on any actions taken prior to the date of this revocation.

\_\_\_\_\_  
Program Participant / Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Program Participant / Personal Representative Printed Name

Description of Personal Representative's authority to act for the program participant:

\_\_\_\_\_





# ACCORD

*Allegany County Community Opportunities and Rural Development, Inc.*

## Disclosure without Consent Notice

ACCORD may, from time to time, disclose program participants' personally identifiable information (PII) without consent, provided ACCORD notifies program participants about the disclosure; provides program participants, upon participants' request, with a copy of the PII to be disclosed in advance; and gives program participants the opportunity to challenge and refuse disclosure of the information prior to ACCORD's disclosure of the PII.

ACCORD may disclose PII without program participants' consent to:

- (1) ACCORD employees or others acting on behalf of ACCORD, such as contractors and subrecipients, if such outside parties provide services for which ACCORD would otherwise use employees; ACCORD determines it is necessary for the services being provided to the program participant; and ACCORD maintains oversight with respect to the use, further disclosure, and maintenance of program participant records, such as through a written agreement, including the destruction of the PII when no longer needed for the purpose of the disclosure;
- (2) ACCORD employees or others acting on behalf of ACCORD, or from a federal or state entity, in connection with an audit or evaluation of ACCORD's programs and/or services, or for the enforcement of or compliance with federal legal requirements; provided ACCORD maintains oversight with respect to the use, further disclosure, and maintenance of program participant records, such as through a written agreement, including the destruction of the PII when no longer needed for the purpose of the disclosure, except when the disclosure is specifically authorized by federal law or by the responsible regulatory official;
- (3) ACCORD employees, others acting on behalf of ACCORD, or a federal or state entity to conduct a study to improve program/service outcomes, including the quality of programs, for, or on behalf of, ACCORD, provided ACCORD maintains oversight with respect to the use, further disclosure, and maintenance of program participant records, such as through a written agreement, including the destruction of the PII when no longer needed for the purpose of the disclosure;
- (4) Appropriate parties in order to address a disaster, health or safety emergency during the period of the emergency, or a serious health and safety risk such as a serious food allergy, if ACCORD determines that disclosing the PII is necessary to protect the health or safety of program participants or other persons;
- (5) Comply with a judicial order or lawfully issued subpoena, provided ACCORD makes a reasonable effort to notify program participants about all such subpoenas and court orders in advance of the compliance therewith, unless:
  - a. A court has ordered that neither the subpoena, its contents, nor the information provided in response be disclosed;
  - b. The disclosure is in compliance with an ex parte court order obtained by the United States Attorney General (or designee not lower than an Assistant Attorney General) concerning investigations or prosecutions of an offense listed in 18 U.S.C. 2332b(g)(5)(B) or an act of domestic or international terrorism as defined in 18 U.S.C. 2331.
  - c. A program participant is a party to a court proceeding directly involving child abuse and neglect (as defined in section 3 of the *Child Abuse Prevention and Treatment Act [42 U.S.C. 5101]*) or dependency matters, and the order is issued in the context of that proceeding, additional notice to the program participant by ACCORD is not required; or
  - d. ACCORD initiates legal action against a program participant or a program participant initiates legal action against ACCORD, then ACCORD may disclose to the court, also without a court order or subpoena, program participant information relevant for ACCORD to act as plaintiff or defendant.
- (6) The Secretary of Agriculture or an authorized representative from the Food and Nutrition Service to conduct program monitoring, evaluations, and performance measurements for the Child and Adult Care Food Program under the *Richard B. Russell National School Lunch Act* or the *Child Nutrition Act of 1996*, if the result will be reported in an aggregate form that does not identify any individual: Provided, that any data collected must be protected in a manner that will not permit the personal identification of program participants by other than the authorized representatives of the Secretary of Agriculture and any PII must be destroyed when the data are no longer needed for program monitoring, evaluations, and performance measurements;
- (7) A caseworker or other representative from a state, local, or tribal child welfare agency, who has the right to access a case plan for a program participant who is in foster care placement, when such agency is legally responsible for the program participant's care and protection, under state or tribal law, if the agency agrees in writing to protect PII, to use information from the program participant's case plan for specific purposes intended of addressing the program participant's needs, and to destroy information that is no longer needed for those purposes; and
- (8) Appropriate parties in order to address suspected or known child maltreatment and is consistent with applicable federal, state, local, and tribal laws on reporting child abuse and neglect.

