COMTREA
Full Board

Friday, September 18, 2020

OPEN SESSION MATERIALS

Join Zoom Meeting
https://comtrea.zoom.us/j/93143257978?pwd=Ujd4K1BCbnduSW02VUpKbEpYblZNQT09

Meeting ID: 931 4325 7978
Passcode: 955401
1. Meeting Open

2. Approval of Agenda

3. Action Items (Anything that requires a vote)
   a. Approval of EFMLA Policy
   b. Approval of MHOH Resident Policy and Procedures

4. Next Scheduled Board Meeting
   a. Monday, October 12, 2020

5. Adjournment
EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT POLICY

This Policy implements the Emergency Family and Medical Leave Expansion Act ("EFMLEA"), effective April 2, 2020. This Policy supplements, and should be interpreted in conjunction with, the Company’s current Family Medical and Leave Act (“FMLA”) policy. Under the EFMLEA, employees who are unable to work so that they may care for children if schools are closed or their daycare is unavailable because of a public health emergency with respect to COVID-19 may be eligible for a period of job-protected leave as described below. This Policy provides an overview of employees’ rights and responsibilities under the EFMLEA.

Eligibility for EFML

To be eligible for Emergency Family and Medical Leave (“EFML”) under this Policy, an employee must have worked at the Company for at least 30 days. Eligibility will be determined as of the date the EFML commences.

Types and Duration of EFML

An eligible employee may take up to 12 weeks of leave between April 2, 2020, and December 31, 2020 for the following reason: an eligible employee is unable to work due to a need to care for a son or daughter under the age of 18 if the son or daughter’s school or place of care has been closed, or the child care provider of such son or daughter is unavailable due to a public health emergency. Any leave taken under this Policy shall count toward any leave to which an employee is entitled under the FMLA Policy in the Employee Handbook.

Definitions

“Public health emergency” means an emergency with respect to COVID-19 declared by a federal, state or local authority.

“School” means an elementary or secondary school.

“Child care provider” means a provider who receives compensation for providing child care services on a regular basis.

Paid Leave

The first ten (10) days of EFML are generally unpaid, except that an employee may elect to use any accrued Paid Time Off (“PTO”) or Emergency Paid Sick Leave (“EPSL”) in accordance with the Company’s PTO Policy or EPSL Policy. Any EFML after the first ten (10) days will be paid by multiplying by two-thirds the employee’s regular rate of pay times the number of hours the employee would normally be scheduled to work ((employee’s regular rate of pay X number of hours employee is normally scheduled to work) X (2/3)). In no event shall the amount of paid EFML, however, exceed $200 in any single day or $10,000 in the aggregate.
If the employee’s schedule varies from week to week to such an extent that the Company cannot determine the hours the employee would normally be scheduled to work, the Company will use the average number of hours the employee worked per day over the prior six months (including hours for which the employee took leave) ending on the date on which the employee takes EFML, or for an employee who has not worked during the preceding six months, the average number of hours per day the employee was expected to normally be scheduled to work at the time of hiring.

**Notice of Need for EFML**

To avoid a delay in EFMLEA protection, when the necessity for EFML is foreseeable, the employee must give notice as soon as possible and practicable under the circumstances. An employee who wants to take EFML must follow normal call-in policies and notify the person an employee would normally notify for an absence. Failure to adhere to normal company call-in procedures can result in discipline, as with any other type of leave.

If an employee unreasonably fails to give the required notice, EFMLEA coverage may be delayed for a period of time. This can result in discipline for absences taken prior to EFMLEA coverage commencing.

**Restoration to Position and Benefits**

Consistent with the FMLA policy, healthcare benefits will be maintained while an employee is on EFML, subject to the payment of premiums explained in this paragraph. For all other benefits, they will be maintained similarly to others on similar forms of leave (paid/unpaid). Employees on EFML will continue to have their premium payments deducted from their paycheck as if they were on non-EFMLEA paid leave.

Employees using EFML are entitled to return to the same position held when EFML commenced, or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment. If the employee would have lost their position even if they had not taken the leave, then there exists no reinstatement right.

**Return to Work**

EFML must be used for its intended purpose. If the qualifying reason for taking EFML ends, then the employee must contact the Company and make arrangements to return to work, unless the employee is entitled to additional leave pursuant to Company policies. Employees on EFML must periodically inform their supervisor, management, or Human Resources of their intent to return to work while on EFML.

**Failure to Return From Leave**

Unless required otherwise by law, if an employee fails to return to work upon expiration of EFML, the Company will apply the provisions of its attendance and disciplinary policy to further absences.
TO THE EMPLOYEE: You are requesting paid sick leave and/or medical leave under FFCRA as described in our EPSL policy. Please review that policy for more information about the EPSL and/or EFML benefits you may be eligible to receive. In order to be considered for these benefits, you must fully complete this form (Sections A and B), turn this form and supporting documentation into Human Resources. Please contact Human Resources at 636-232-2302 or hr@comtrean.org if you have any questions.

I AM UNABLE TO WORK OR TELEWORK AND AM REQUESTING EPSL LEAVE BECAUSE:

SECTION (A)  REASON FOR LEAVE  (Check only ONE):

(1)  I am subject to a Federal, State or local quarantine or isolation order related to COVID-19*

(2)  I have been advised by a health care provider to self-quarantine related to COVID-19*

(3)  I am experiencing COVID-19 symptoms and am seeking a medical diagnosis*

(4)  I am caring for an individual subject to an order described in (1) or self-quarantine described in (2)*

(5)  I am experiencing any other substantially-similar condition specified by the US Department of Health and Human Services*

(6)  I am caring for a child whose school or place of care is closed due to COVID-19 related reasons

The name of the place of care that has been closed and is unavailable: ____________________________

The name of the child(ren) being cared for: ________________________________

To the extent any of the child(ren) above are older that fourteen, the following special circumstances require that I care for them during daylight hours: __________________________

By signing below, I certify that no other suitable person is available to care for the child(ren), and that if suitable care becomes available, I will notify the company.
*NOTE: You are required to provide COMTREA with documentation in support of the reasons for your paid sick leave and medical leave. These documents may include a copy of the quarantine or isolation order related to COVID-19, AND/OR written documentation by a health care provider advising you to self-quarantine due to COVID-19. You may also submit written notice from a childcare provider.

SECTION (B) DATES OF YOUR REQUESTED LEAVE

Start Date of Requested Leave

End Date of Requested Leave

CERTIFICATION OF EMPLOYEE: I certify that the information contained on this form and documentation submitted is truthful and accurate.

Name (Printed): 

Signature: 

Date: 

FMPRS2020-06
Approved 04/06/2020
MARY'S HOUSE OF HOPE AT A SAFE PLACE
ADDRESS
PHONE / FAX

APPLICATION CHECKLIST

Copies of birth certificates and social security cards for all members of the family that will reside in the unit

Copy of applicant’s photo identification

A $25.00 non refundable application fee (money order made out to “MHOH at ASP”).

Proof of Income (copy of check stubs, check and/or benefits award letter).

Proof of enrollment in a job training and/or educational program. If not registered yet must supply copy of Individual Transitional Plan (ITP).

Letter from Director/Advocate recommending need for transitional housing at MHOH at ASP.

Letter from applicant as to why MHOH at ASP is an appropriate choice for her (and family).

Once all of the documents/forms have been obtained, please contact the Program Director at ---------- to set up an interview.
# APPLICATION FORM

Mary’s House of Hope (MHOH) at A Safe Place (ASP) Transitional Housing Program provides women with an opportunity to increase their education, develop new job skills and gain diplomas or certifications and/or gain the financial tools needed for long-term sustainability for independent living.

Please answer all questions to the best of your ability by printing or typing your responses.

**OFFICE USE ONLY:**
Unit Assigned: ____________

**MHOH at ASP Confidentiality Policy:** After this form is reviewed, it will be kept in a secure file. Only MHOH at ASP staff will have access to it. None of the details you give as to yourself or your family will be released to a third party without your written consent. The only exception relates to the instances of suspected child abuse and neglect. All of MHOH at ASP staff members are mandated reporters and required by law to notify the proper authorities if investigation of child maltreatment or endangerment seems warranted.

## BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>APPLICANTS SOCIAL SECURITY NUMBER</th>
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<tr>
<td>DATE OF APPLICATION: ______________________</td>
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<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME / INITIAL</th>
<th>DATE OF BIRTH</th>
<th>AGE</th>
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<th>CURRENT ADDRESS: STREET</th>
<th>CITY</th>
<th>STATE/ZIP</th>
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<th>PRIOR ADDRESS (OTHER THAN SHELTER ADDRESS): STREET</th>
<th>CITY</th>
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<th>PHONE (PRIMARY)</th>
<th>PHONE (ALTERNATE)</th>
<th>PHONE (ALTERNATE)</th>
<th>COUNTY OF LAST RESIDENCE</th>
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<tr>
<th>MARITAL STATUS</th>
<th>RACE/ETHNICITY</th>
<th>IF MULTI RACIAL: CHECK ONE OR MORE OF THE FOLLOWING:</th>
<th>ETHNICITY</th>
<th>LANGUAGE USED AT HOME</th>
<th>NEED AT INTERPRETER?</th>
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<tr>
<td>☐ MARRIED</td>
<td>☐ CAUCASIAN/WHITE</td>
<td>☐ CAUCASIAN/WHITE</td>
<td>☐ HISPANIC OR LATINO</td>
<td>☐ ENGLISH</td>
<td>☐ FOR SPOKEN ENGLISH</td>
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<td>☐ DIVORCED</td>
<td>☐ AFRICAN</td>
<td>☐ AFRICAN</td>
<td>☐ SPANISH</td>
<td>☐ SPANISH</td>
<td>☐ FOR WRITTEN ENGLISH</td>
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<td>☐ SEPERATED</td>
<td>☐ AMERICAN/BLACK</td>
<td>☐ AMERICAN/BLACK</td>
<td>☐ BOSNIAN</td>
<td>☐ BOSNIAN</td>
<td>☐ FOR BOTH</td>
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<td>☐ SINGLE</td>
<td>☐ ASIAN</td>
<td>☐ ASIAN</td>
<td>☐ RUSSIAN</td>
<td>☐ RUSSIAN</td>
<td>☐ TO ASSIST CHILDREN</td>
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<td>☐ PACIFIC ISLANDER</td>
<td>☐ PACIFIC ISLANDER</td>
<td>☐ CHINESE</td>
<td>☐ CHINESE</td>
<td>☐ IN USING ENGLISH</td>
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<td>☐ MULTI-RACIAL</td>
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**APPLICATION FORM**

<table>
<thead>
<tr>
<th>HOUSING SITUATION PRIOR TO STAY AT REFERRING SHELTER?</th>
<th># TIMES IN SHELTER DURING RELATIONSHIP WITH ABUSER?</th>
<th># TIMES IN SHELTER SINCE AGE 18? (Please list Shelter contact information)</th>
<th>EDUCATION: Last grade attended</th>
<th>EDUCATION: Degree Received</th>
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<tbody>
<tr>
<td>q OWNED HOME WITH ABUSER</td>
<td></td>
<td></td>
<td>q Prior to 8th grade</td>
<td>q Graduated 8th grade</td>
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<tr>
<td>q RENTED HOME WITH ABUSER</td>
<td></td>
<td></td>
<td>q 8th grade</td>
<td>q High school diploma or GED</td>
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<tr>
<td>q HAD INDEPENDENT HOUSING WHERE ABUSER LIVED WITH ME</td>
<td></td>
<td></td>
<td>q Sophomore year</td>
<td>q Associate / 2 yr degree</td>
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<tr>
<td>q HOMELESS; ABUSER GAVE ME A PLACE TO STAY</td>
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<td></td>
<td>q Junior year</td>
<td>q Bachelor’s</td>
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<td>q OTHER</td>
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<td></td>
<td>q Senior year</td>
<td>q Master’s</td>
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**CURRENT EMPLOYMENT**

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<tr>
<th>NAME OF EMPLOYER</th>
<th>POSITION OR TYPE OF WORK YOU DO</th>
<th>WORK HOURS</th>
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**FINANCIAL SUPPORT**

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<tr>
<th>SOURCES OF INCOME</th>
<th>AMOUNT</th>
<th>HOW OFTEN DO YOU RECEIVE EACH TYPE OF INCOME?</th>
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<td>CHOOSE 1 OPTION FOR EACH SOURCE OF INCOME</td>
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<td>ANNUALLY MONTHLY WEEKLY DAILY HOURLY OTHER</td>
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<th>EMPLOYMENT</th>
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<td>FOOD STAMPS</td>
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<td>SSI/DISABILITY</td>
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<td>OTHER PUBLIC ASSISTANCE</td>
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<td>CHILD SUPPORT</td>
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<td>SAVINGS</td>
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</table>
**APPLICATION FORM**

**FINANCIAL OBLIGATIONS**

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<tr>
<th>BILLS/DEBTS</th>
<th>AMOUNT OWED</th>
<th>DESCRIBE BELOW ANY PAYMENT PLANS WORKED OUT TO REPAY THE AMOUNT OWED</th>
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<td>UTILITIES</td>
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<td>CAR PAYMENT</td>
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<td>SCHOOL LOANS</td>
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<td>CREDIT CARD DEBT</td>
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<td>OTHER</td>
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<th>VEHICLE</th>
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<th>YES</th>
<th>NO</th>
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WILL YOU HAVE A CAR?
☐ Yes  ☐ No

WILL YOUR ABUSER KNOW WHICH CAR IS YOURS?
☐ Yes  ☐ No

**CHILDREN:** Please answer the following questions for each of the children who will be living with you at MHOH at ASP.

Please provide a copy of the last court order showing custody arrangements for each minor child.

<table>
<thead>
<tr>
<th>CHILD NAME</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>SSN</th>
<th>Does the abuser have legal access?</th>
<th>School and Grade</th>
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APPLICATION FORM

NON RESIDENT CHILDREN

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<tr>
<th>DO YOU HAVE CHILDREN WHO WONT BE WITH YOU AT MHOH AT ASP?</th>
<th>IF YES DO YOU AND YOUR ABUSER HAVE JOINT CUSTODY OF ANY OF THEM?</th>
<th>DOES YOUR ABUSER HAVE FULL CUSTODY OF ANY OF THEM?</th>
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<tr>
<td>□ Yes</td>
<td>□ Yes</td>
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CURRENT SITUATION

1. Why are you seeking transitional housing at this time?

2. What do you hope to achieve while you are at MHOH at ASP?
APPLICATION FORM

I understand that by signing below, I confirm the responses I’ve given in this application and request services for myself and my family

Signature: ___________________________________________  Date: ______________________

PLEASE COMPLETE THE RELEASES OF INFORMATION BELOW

I hereby authorize MHOH at ASP to contact the following persons for a reference check:

Shelter Advocate: ____________________________________________________________

Agency: _________________________________   Phone: ________________________

Phone: ____________________________
OVERVIEW AND WELCOME

Mary’s House of Hope (MHOH) at A Safe Place (ASP) Transitional Housing Program will provide women with an opportunity to increase their education, develop new job skills, and gain diplomas or certificates and/or gain the financial tools needed for long-term sustainability for independent living. The transitional housing is an interim step in the achievement of this long-term goal. MHOH at ASP is a division of Community Treatment (COMTREA), a Comprehensive Health Center located in Jefferson County Missouri. To qualify for the MHOH Transitional Housing Program the participant must be enrolled in an individualized goal plan that will move the individual from where they are now to independent and sustainable living. The participant must remain in good standing within their program while living in the Transitional Housing apartments and demonstrate consistent progress towards the goal plan. The maximum length of time in transitional housing at MHOH is 24 months.

MHOH at ASP staff have the right to request that a family leave if that family is out of compliance with seeking treatment established by the family’s advocate and the family, or if the family is out of compliance with the rules set forth in the contract. A warning and action plan might be given at the advocate’s discretion; however, each family needs to understand that violation of the terms of the Resident Agreement may result in "immediate termination" of the contract.

*MHOH housing and support services are provided without regard to race, religion, sexual preference, handicap, age or ethnicity.*
PROGRAM SERVICES

ADVOCACY/CASE MANAGEMENT: Residents will meet with an advocate at specified intervals and work on developing goals, breaking down barriers, and celebrating achievements and successes. During this time, residents will report on the progress of their individualized goal plan with identification of accomplishments. Residents will also work with their advocate on securing any needed community resources available to them. Together, they will work on a plan for sustainability while residing at MHOH and for when the resident has completed their stay.

THERAPEUTIC NEEDS: The resident can continue with the therapist at ASP or get a referral to one of the COMTREA Programs. Residents and their children may continue to attend groups and social events with ASP residents as long as needed. The MHOH at ASP program may also include such groups as financial independence, repairing credit scores, minor house repairs (not at MHOH), minor car repairs, self-defense, home safety planning, gardening, etc. through community-based partnerships. Attendance and participation are strongly encouraged.

COMMUNITY MEETINGS: The MHOH residents will meet quarterly or as needed to talk about how things are going within the Transitional Housing unit. Residents can brainstorm about how to approach challenges, discuss difficulties occurring within the apartment complex, or work through conflicts with other families. Attendance is required for the first six months of living in the Transitional Housing unit and is strongly suggested thereafter.

PEER SUPPORT GROUPS: Participation in the monthly peer support group is required for the first six months and strongly encouraged thereafter. The peer support group provides a forum for residents to share how things are going, share successes and failures, gain knowledge from others successes, and gather helpful resources. Leadership skills will be modeled and taught so that each resident has an opportunity to take on a leadership role in a safe environment. Therapeutic topics may be introduced when needed.

MARY’S HOUSE OF HOPE POLICIES

PROGRAM REQUIREMENTS: Adult residents and their children must actively participate in the MHOH program. This means attending, participating, and reporting progress in the individualized goal plan. If the adult, head of the household, fails to achieve the individualized goals per the plan, discharge from MHOH Transitional Housing will follow with a 14-day notification. Immediate eviction can be initiated for violation of the resident agreement. All adult residents must agree to meet with her advocate at specified intervals (weekly/bi-weekly/monthly/quarterly) to go over goals, objectives, and to formulate solutions to problems and barriers to ensure program success.

HOUSING: MHOH at ASP will consist of one, two and three bedroom apartments that will be fully furnished. Each woman and her child/children will occupy an individual apartment according to family size. All furniture and furnishings included, but not limited to, are beds &
bedding, linens, pots, pans, dishes, kitchen utensils, stove, refrigerator, living room furniture and laundry facilities. Residents will be expected to maintain the apartment, including all furnishings and contents, and leave them in the same condition as they were upon move in.

**HOUSEKEEPING & REPAIRS**: Each woman is responsible for keeping her apartment clean and odor free. At a minimum, once a week the apartment floors should be swept and mopped, bathrooms cleaned, fixtures wiped down, and appliances cleaned properly. All residents are expected to participate in keeping the common areas clean and tidy at all times. Twice a month there will be a staff led inspection of each apartment in order to make notes of any needed repairs and preventative maintenance per COMTREA requirement. This includes external vendors for pest control and other service needs as indicated (HVAC, etc.). At this time, staff will discuss any concerns regarding condition of the apartment and common areas with each resident. When needed, suggested cleaning improvements must be made by the resident or discharge may occur. If needed, a cleaning day for common area may be designated and all resident must participate. Staff must be allowed in residents’ homes at times of inspections and residents may not limit access to authorized MHOH staff. Residents will be responsible for supplying their own lock for each of their assigned storage units.

For repair and maintenance, contact the designated number at [insert phone number]. Routine repair and maintenance is available during regular business hours Monday – Friday; evening and weekend non-emergent repairs are the responsibility of the resident.

**LAUNDRY**: Each resident is responsible for doing the laundry for their family, as well as the bedding, bath towels, kitchen towels and any cleaning cloths that are provided. Each resident will be responsible for supplying their own approved laundry detergent and softener. Washing machines will be provided in a common area. Residents must be respectful of the time they are using the machines. Laundry should not be left unattended beyond the wash/dry cycle time.

**PHONES**: Residents are responsible for the plan and payment for their own mobile phone. Please remember to continue to use the safety guidelines learned at ASP. Residents may talk with their advocate for further information.

**KEYS**: There will be no physical keys. Each resident will be issued a key ring fob that is programmed to their specific apartment and the front door of the building. For everyone’s safety, the front and back door will be locked at all times. If keys are lost, immediately contact ASP staff member. The charge for a replacement fob is $10.00.

**INTERNET**: Each apartment will have internet access capacity through a designated Internet Service Provider (ISP). Each tenant is responsible for their own computer/laptop, connection and the incurred charges for internet service.

**MAIL**: Each resident will be provided a mailing address on the day they move into MHOH. The mail is picked up M-F and delivered to ASP for distribution.

**PETS**: Pets are not allowed at MHOH. Service animals are permitted consistent with our policy.
PEST CONTROL: MHOH strives to remain a pest free environment. Please store, cook, prepare and eat food in kitchen and dining areas only. Wash dishes, pots and pans after every meal and store unused foods and leftovers in a sealed container.

CONFIDENTIAL LOCATION: The safety of MHOH residents is a priority. The location of the apartment and the address must be kept confidential. Residents may not bring anyone to the MHOH property. You may continue to have one approved safe person. If you are getting a ride from your already approved safe person, they may pick you up in the MHOH driveway. All other rides must be met at the approved site a block away. If an abuser finds the victim or shows up on our property this will be addressed and the police and 911 will be called immediately. The family may need to leave the facility if safety is compromised.

SUSTAINABILITY /FINANCIAL ASSISTANCE: Residents of MHOH will participate in the Circle of Hope program which will aid in helping each family with financial needs while residing in transitional housing. This will consist of meeting with community members who are willing to lend support to this project. Staff will assist in helping residents maintain some confidentiality while still meeting the goals of the Circle of Hope program. Social events will be planned with community members and residents in order to work together on building a plan for continued sustainability, support, and resources. The community partners are our biggest supporters and their desire to give support is paramount to the success of the MHOH Program.

MEDICAL, DENTAL, AND MENTAL HEALTH SERVICES: If needed, referrals can be provided to COMTREA or the providers in the region consistent with resident choice. Please check with your Advocate regarding these resources.

FOOD, HOUSING SUPPLIES, PERSONAL CARE ITEMS: Residents will be responsible for supplying all of their food, cleaning supplies, and personal care items. Your advocate is available to meet with you to find needed resources such as SNAP and food pantries as well as other community partners who can help with needed items. Donations may be available for distribution from various organizations that support ASP and MHOH.

TRANSPORTATION: Residents will be responsible for their own transportation. Your advocate will work with you on your transportation situation. Resources will be given. If you have and/or drive a vehicle on MHOH property, you must provide staff with a valid driver’s license, insurance card, and make and model of the car. Information on Jeffco Express, a public bus transportation system serving Jefferson County, MO, will be provided.

RESIDENT BEHAVIOR CODE: Any kind of abusive behavior of other residents, staff or community partners will not be tolerated at MHOH.

*If a resident or her children threaten or intimidate anyone of the above mentioned the resident and family will be exited from MHOH immediately.

* If inappropriate or disruptive behavior occurs and a corrective action is assigned, it must be complied with or discharge will follow. MHOH at ASP reserves the right to terminate the resident agreement at any time as deemed necessary.
* In the event of conflict with other residents, we encourage you to use your learned skills to work through the issue. When this is not possible, you may ask for your advocate to mediate the conflict. If the conflict is with staff, please contact the Director of ASP.

**DRUGS/ALCOHOL/SUBSTANCE USE:** The use of illegal substances, drugs or alcohol on MHOH property is prohibited. Failure to comply will result in an immediate discharge. If treatment is assigned, the resident must comply or be discharged. MHOH reserves the right to ask residents verbally for a drug test at the resident’s cost when it is deemed necessary. Drug tests must be completed within a twenty-four (24) hour period of the verbal request. Refusal will result in a discharge from MHOH. If the resident is engaged in a current treatment program, the resident is encouraged to continue participation while living at MHOH. Your Advocate has a supply of literature and information about AA and other programs for your reference.

**SMOKING:** Smoking will be allowed only in the designated smoking area. There will be smoking receptacles which must be used. If a resident does not comply with this policy, discharge may follow. Smoking in the residential building will not be tolerated. Smoking in an unapproved area will result in immediate discharge from MHOH.

**NOISE AND DISTURBANCES:** Social and family gatherings among resident families at MHOH is welcome. Gatherings must not be loud, obscene, or objectionable to other residents. Televisions, stereos, radios and any other electronic type equipment must be kept at a reasonable volume at all times so that neighbors are not disturbed.

**OVERNIGHT EXCURSIONS:** Overnights away from MHOH are allowed especially on weekends. During the week the resident must complete all program duties. Please let your advocate know if you are planning to be away overnight, for your safety and the safety of others. If you plan to return early, please notify staff at ASP before entering the property. Unapproved excessive, or extended overnight absences may result in discharge due to failure to participate in the program.

**THEFT:** MHOH is not responsible for items left unattended, lost or stolen items. Individuals found guilty of theft will be asked to leave the program.

**WEAPONS:** Weapons of any type are strictly prohibited at MHOH at ASP. Staff reserve the right to determine any questionable item and you may be asked to dispose of this item. Toys such as guns, knives, swords, slingshots, or other harmful and violent toys are prohibited as well.

**BUILDING EMERGENCIES** – It is the responsibility of each resident to be familiar with your escape route and access to the fire extinguisher within each unit.

**RIGHT OF ENTRY** – Designated staff of MHOH at ASP and/or Community Treatment, Inc. will have the ability to enter the residence.
RESIDENT AGREEMENT

To all parties concerned, let it be known that understanding and agrees to the terms listed below in this contract in order to participate in the Mary’s House of Hope at ASP (MHOH at ASP) Transitional Housing Program. I understand that failure to comply with the terms herein agreed upon will result in departure from the program.

The terms of this agreement for transitional housing are for up to no more than 24 months from the signed date of this document. I understand that this agreement is contingent upon demonstrating consistent progress towards my individual goal plan. 

I will meet with my Advocate at specified intervals to review progression of individual goal plan. 

I agree to apply for any and all services and entitlements that I qualify for, including but not limited to child support, food stamps, and medical coverage, and to disclose this information. 

While in the MHOH at ASP Transitional Housing Program, I understand that I am required to participate in the individual goal plan. 

Any family member owning or operating an auto will have the car properly registered and licensed according to the state laws and the vehicle will carry current and valid insurance. My family and I agree to not operate a vehicle that does not comply with these requirements. (This information is maintained in the COMTREA business office.) 

I agree that there will be no overnight guests at MHOH at ASP Transitional Housing in compliance with the policies of MHOH at ASP. 

I will take responsibility for my children and provide close supervision at all times. 

Thermostat setting guidelines are 70 degrees for heat, and 78 degrees for cool. I agree to abide by these settings and respect utility costs by turning off all ceiling fans/lights/etc. when not in use. Noncompliance of this setting could result in a $50 utility charge. 

I agree to no alcohol and/or drugs on the MHOH at ASP property and a drug screen could be required of adults and adolescents (13 and older) per the MHOH at ASP Policies at the cost of the resident. Drug tests must be completed within a 24 hour period of the request. 

Smoking will be allowed only in the designated smoking area. Smoking in the residential building will not be tolerated. Smoking in an unapproved area will result in immediate discharge from MHOH _______. 

Inspections will be conducted of each housing unit twice a month. I will care and clean for my home and leave it just as I found it at move-in.
I understand that weapons are not permitted on site.

I am responsible for any damage I or my children cause to any MHOH at ASP residence, structure and internal contents per the itemized list.

MHOH at ASP, Community Treatment, Inc and its Board, employees, and volunteers is not responsible for any lost or stolen items.

MHOH at ASP shall be used for residential purposes only and shall be occupied only by the persons named in the MHOH at ASP Agreement. Substitution or addition of any residents will be allowable only with prior written consent of the MHOH at ASP staff. The premises shall be used so as to comply with all state, county and municipal laws and ordinances. Residents shall not use their home or permit it to be used for any disorderly or unlawful purposes or in any manner so as to interfere with either the administration of MHOH at ASP and its goals or other neighboring family’s enjoyment of their residences.

Each MHOH at ASP resident has an individual transitional plan according to their ability and needs. Therefore each plan may differ in funding and personal responsibility. MHOH at ASP has a NO DRAMA policy. Therefore no gossip, backbiting, comparing or criticizing will be tolerated. We promote unity and respect for ourselves, each other, the staff and mission. If any MHOH at ASP resident has an issue with a staff member, policy or other participant, the first method of resolving the issue is by working it out through taking a personal inventory and communicating in positive ways. This process should be discussed with your Advocate before moving forward. In this way, we all grow together and become stronger in our ability to relate to those around us and the outside world.

Each resident will pay a percentage of their income as a housing fee using the Income and Rent calculation worksheet attached. The amount that you are responsibly for at this time is $_______ per a month. This will be reevaluated every 3/6 months or when there is a change in income capacity. Changes will be updated through an addendum to this agreement.

The monthly rental amount includes trash pick-up, heat, water and sewer. The amount does not include internet, telephone and cable, which is the sole responsibility of the resident.

The resident shall indemnify and hold harmless MHOH at ASP, Community Treatment, Inc and its Board, employees, and volunteers from all liability for death or injury to any person or loss or damage to the property of any person resulting from the use of the property by the resident.

I understand that federal, state, and local governments require grant recipients (i.e.: MHOH at ASP) to provide basic client information in order to receive funding. I agree to the sharing of this information.
Falsification of information or the withholding of information pertinent to the provision of the MHOH at ASP program constitute a violation of this contract and may be grounds for termination.

I understand that in exchange for being provided reduced rent; a safe place for my family, and services, I cannot stay at MHOH at ASP any longer than specified in my contract. If I am asked to leave due to a violation or end of contract, I understand that I must vacate as soon as possible and within the timeline given to me by staff at MHOH at ASP. I understand that if I fail to do that, legal action may be taken against me.

Subject to compliance with the provisions contained hereinabove, this contract is in effect for up to twenty-four (24) months or ending date as specified in the agreement. I agree to abide by these requirements and to ensure that my children are also in compliance.

______________________________  ____________________  ____________________
Resident signature  Date  MHOH at ASP Staff
Resident Name: _________________________________    SSN: _____ - _____ - ________
Address of Unit: ____________________________________________________________________

Date Prepared: _________________ Prepared By: _____________________
Type of Change: _________________ Effective Date: ____________________

**ASSETS:** (examples: land (real property), annuity, savings, average checking account balance for six months, insurance policies, burial plot)

<table>
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<tr>
<th>FAMILY MEMBER</th>
<th>DESCRIPTION OF ASSET</th>
<th>CURRENT FACE VALUE OF ASSETS</th>
<th>ACTUAL INCOME FROM ASSETS</th>
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<td>HOH:</td>
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1.  TOTAL NET FACE VALUE OF ASSETS (Item 1): (1)
2.  TOTAL ACTUAL INCOME FROM ASSETS (Item 2)*: (2)
3.  IMPUTED INCOME FROM ASSETS (Item 3)*: (3)**

*Complete only if Item 1 is greater than $5000  **Item 1 x .02

**ANTICIPATED ANNUAL INCOME:**

<table>
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<tr>
<th>FAMILY MEMBER</th>
<th>WAGES/SALARIES</th>
<th>SOCIAL SECURITY</th>
<th>OTHER PUBLIC ASSISTANCE</th>
<th>OTHER</th>
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<td>HOH:</td>
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4.  TOTALS: (4)
5.  ASSET INCOME TO BE CONSIDERED (ENTER THE GREATER OF ITEM 2 OR 3): (5)
6.  TOTAL ANNUAL INCOME: (6)

**EXPENSES AND ALLOWANCE INFORMATION:**

Number of dependents under 18 (include full-time students and disabled family members)

DO NOT include head of household, spouse or foster children. (7) ________________

Is the head of household or spouse at least 62 years of age or disabled? (8) Yes ____  No _____

Total Child Care Expenses:
a. Expenses that enable a family member to work:
   Name of Household Member enabled to work: _____________________________ (9a) ________________

b. Expenses that enable a family member to further education:
   Name of Household Member enabled to further education: ______________________ (9b) ________________

Total Disability Expense: (10) ________________
Names of Household Members enabled to work: ________________________________

Total Medical Expenses Not Reimbursed by Others: (11) ________________
# Income and Rent Calculation Worksheet

**For MHOH at ASP Transitional Housing**

12. **Total Annual Income** (enter amount from item 6) (12)

13. **3% of Annual Income** (Item 12 x .03) (13)

14. **Dependent Deduction** (enter $480 x Item 7) (14)

15. **Allowable Child Care Expenses**
   - (Item 9a + Item 9b BUT expenses allowed for 9a must not exceed employment income of household member(s) enabled to work.)

16. **Total Disability Assistance Expense** (enter amount from item 10) (16)

17. **Allowable Disability Assistance Expenses**
   - (Item 16 minus Item 13 BUT never more than employment income of Household member(s) enabled to work.)

18. **Total Medical Expenses**
   - (Enter amount from Item 11 **ONLY** if head of household or spouse is at least 62 or disabled.)

19. **Allowable Medical Expenses**
   - (Complete **ONLY** if head of household or spouse is at least 62 or disabled.)
   - a. If Item 16 is greater than Item 13, allow all medical shown in Item 18.
   - b. Otherwise, enter Item 16 + Item 18 minus Item 13 (if result is negative, enter zero).

20. **Elderly/Disabled Household Deduction**
   - (Enter $400 **ONLY** if head of household or spouse is at least 62 or disabled.)

21. **Total Allowances** (add Items 14, 15, 17, 19 & 20) (21)

22. **Annual Adjusted Income** (Item 12 minus 21) (22)

23. **Monthly Income** (Item 12 divided by 12 months) (23)

24. **Monthly Adjusted Income** (Item 22 divided by 12 months) (24)

25. **30% of monthly adjusted income** (Item 24 x .30) (25)

26. **10% of monthly income** (Item 23 x .10) (26)

27. **Total Tenant Payment** (enter larger of Item 25 or 26) (27)

28. **Contract Rent** (28)

29. **Applicable Utility Allowance** (enter amount from PHA schedule) (29)

30. **Gross Rent** (Item 28 + Item 29) (30)

31. **Total Tenant Payment** (same as Item 27) (31)

32. **Tenant Rent**
   - (Item 31 minus Item 29. If result is negative, enter zero.)

33. **Utility Reimbursement**
   - (If Item 32 is zero, enter Item 29 minus Item 31.)

34. **Housing Assistance Payment** (Item 28 minus Item 32) (34)

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**Unit is at or below FMR:** Yes _____  No _____  
**BEDROOM SIZE:** ____________

**Unit is 1% to 10% over FMR:** Yes _____  No _____