

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING

(Revised September, 2004)

COVER PAGE

CHECK LIST:

This application requires the following to be complete. Applicant should retain a copy.
Complete Forthcoming

- | | | |
|--------------------------|--------------------------|-------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. UNIVERSAL PRELIMINARY APPLICATION – 4 pages. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. FIVE YEAR HOUSING HISTORY form |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. MEDICAL CERTIFICATION form |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. CERTIFICATE OF HOMELESSNESS (if required) |

Presumptive Eligibility Information (For Housing Providers use Only)

Date on which
found eligible: M _____ D _____ Y _____

Date removed
from waitlist: M _____ D _____ Y _____

Reason/s off list:

- 1= Accepted into program
- 2= Found ineligible before intake
- 3= Withdrew application
- 4= Died
- 99= Unknown/lost to follow up

Additional comments:

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING

(Revised June, 2004)

Name of the HIV HOUSING PROVIDER to which applicant is applying: _____

Date mailed: ___/___/___ Referring Person: _____

Agency: _____ Phone: _____

Client code of head
of household:

_ _ _	_ _ - _ _ - _ _	_ _ _ _
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1st 3 letter of mother's
first name

Birth (MM-DD-YY)

Last 4 digits of SSN

A) BASIC INFORMATION

Applicant: _____ DOB: ___/___/___

Primary Language: _____ Social Security #: _____ - _____ - _____

Phone # where applicant accepts calls (if any): () _____

Pager: () _____

Cell Phone: () _____

Address: _____ City/Town: _____ ZIP: _____

Place to send mail (if different): _____

City/Town: _____ ZIP: _____

Gender: Male ___ Female ___ Transgender ___

Race: Hispanic/Latino ___ Caucasian ___ African American ___ Haitian ___ Asian ___ Native American ___

Other _____

Existing Case Managers (other than referring person) assisting with HIV-related issues (*optional*):

Name/Agency: _____ Phone: _____

Name/Agency: _____ Phone: _____

B.) HOUSEHOLD COMPOSITION/ INCOME:

Most HIV housing programs require that residents meet low income requirements set by the U.S. Department of Housing and Urban Development. List all persons in the planned household with any form of income including live-in boyfriends/ girlfriends. List children who are certain to live with applicant from move-in date. *(Continue in section K)*

<i>Names of individuals who will live with the applicant</i>	<i>Relationship to applicant</i>	<i>Age</i>	<i>Source(S) of income * (Wages, SSI, AFDC, etc.)</i>	<i>Monthly Income*</i>	<i>Annual Income*</i>
Applicant	Self			\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
Total Household Income:				\$	\$

** Leave blank for official Personal Care Attendant for whom medical documentation can be supplied evidencing this role.*

C.) MEDICAL ELIGIBILITY:

Please have applicant’s physician complete attached MEDICAL CERTIFICATION form and submit with this application to verify positive HIV status or diagnosis of AIDS for applicant and/or household members (see page 6).

Note to housing managers: HUD has deemed this medical eligibility form as an acceptable form of documentation of HIV status. However, they do suggest that once an applicant has been accepted into your program, a letter from their medical provider on stationary should be placed into the resident’s file.

D.) HOUSING STATUS:

Please check the box below that best describes the applicant’s housing situation for which supporting documentation can be supplied. Check only one box and be certain documentation from a third party on letterhead stationary can be produced at a later date to verify this status. Some HIV Housing Providers will have precise requirements as to the source and content of such supporting documentation.

<input type="checkbox"/>	Living in a shelter.
<input type="checkbox"/>	Living on the street (having no fixed, regular, nighttime residence).
<input type="checkbox"/>	Living in Department of Transitional Assistance Program.
<input type="checkbox"/>	Living in a transitional program (i.e. provides services on site designed to prepare the individual to move into more independent permanent housing) and homeless immediately prior.

<input type="checkbox"/>	Living in and receiving care from an institution not designed for long term residence (e.g. hospital, rehabilitation facility etc.)
<input type="checkbox"/>	Doubled up (living temporarily with friends or relatives)
<input type="checkbox"/>	In imminent danger of losing housing through no fault* of own and has received “summary process summons” from the court to proceed with an eviction (applicant need not have actually been to housing court).
<input type="checkbox"/>	Renting an apartment using a transitional subsidy such as AHVP or DMH.
<input type="checkbox"/>	Renting an apartment using a 2-year HOPWA certificate or a 2 year TBRA HOME certificate and was homeless immediately just prior to using 2 year subsidy.
<input type="checkbox"/>	Living in substandard housing (i.e. living in a unit that endangers the health, safety, or well being of the household due to being dilapidated, or due to inadequate source of heat or inadequate indoor plumbing (including toilet, and bathing facilities, or lack of electricity.
<input type="checkbox"/>	Rent burdened - paying between 50% or more of gross income toward rent and utility costs for at least 90 days (based on average monthly utility payment, excluding phone, over 12 months).
<input type="checkbox"/>	Rent burdened - paying 75% or more ...
<input type="checkbox"/>	Other (briefly describe):

E.) CERTIFICATE OF HOMELESSNESS:

Some HIV housing programs require that applicants submit an official CERTIFICATE OF HOMELESSNESS form to be in compliance with requirements of their funding sources.

F.) HOUSING HISTORY:

FIVE YEAR HOUSING HISTORY form. Provide as much detail as possible.

Has the applicant ever lived in subsidized housing? No Yes If yes, where? _____

When (from – to): _____ In whose name was the apartment? _____

H. ADDITIONAL ELIGIBILITY:

Some HIV housing programs require, in addition HIV verification, that applicants belong to other specific population groups. A signature below indicates that the applicant belongs to the target population, in every respect, for this housing resource.

The applicant certifies that he/she qualifies as a member of the special target population for the HIV housing program to which this application is being. The applicant can supply supporting documentation upon request to demonstrate such eligibility.

Applicant Signature: _____

Date: _____

MEDICAL CERTIFICATION FORM

Instructions to applicant: You should fill out Sections A and B and have your physician complete Section C and send to the HIV housing providers to which you are applying.

Section A. Request for Physicians Certification of HIV Status

Dear Medical Provider,

Your patient, _____, is applying for subsidized housing for persons living with HIV/AIDS. These programs may only consider persons with a diagnosis of AIDS or who are HIV+. By signing in Section B below, the individual named authorizes you to release to us the information requested on this page.

Section B. Authorization for Release of Information

I, _____, an applicant for subsidized housing for persons with HIV/AIDS hereby authorize _____, my health care provider, to release the information requested on this form to the program staff of the entities listed above:

Applicant/Date

Witness/Date

Section C. Physician's Certification

I, _____ (please print name), provide primary medical care for _____. For the purpose of his/her application for housing for persons with HIV/AIDS, I hereby certify that he/she:

_____ has a diagnosis of AIDS

_____ does not have an AIDS diagnosis but is HIV symptomatic or has (any) conditions arising from the virus.

_____ is disabled due to HIV

_____ none of the above

Medical Provider Signature

Date

Medical Provider Name Printed

Phone Number

Clinic Name and Address

FIVE YEAR HOUSING HISTORY

(Make multiple copies of this page as needed)

Please list the following information about where the applicant has lived for the past five years. Please note: A lack of rental history does not necessarily disqualify the applicant. Substitute a contact person when no landlord was involved (e.g. shelter social worker, transitional program case manager etc.)

Applicant's current address: _____ Lived here from _____ to present.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name: _____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name: _____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name: _____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name: _____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name: _____Phone:_____

May we call this person for a reference? Yes___No___

(Use additional page if necessary)

