# 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

	1.	UNIVERSAL PRELIMINARY APPLICATION – 4 pages.
	2.	FIVE YEAR HOUSING HISTORY form
	3.	MEDICAL CERTIFICATION form
	4.	CERTIFICATE OF HOMELESSNESS (if required)

# Presumptive Eligibility Information (For Housing Providers use Only)

Date on which found eligible: MDY	Reason/s off list:
Date removed from waitlist: MDY	<ul> <li>1= Accepted into program</li> <li>2= Found ineligible before intake</li> <li>3= Withdrew application</li> <li>4= Died</li> <li>99= Unknown/lost to follow up</li> </ul>
Additional comments:	

# UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING

(Revised June, 2004)

mailed:// Re	ferring Person:		
ncy:		Phone:	
Client code of head			
of household:	1 <sup>st</sup> 3 letter of mother's first name	Birth (MM-DD-YY)	Last 4 digits of SSN
BASIC INFORMATION			
Applicant:			DOB://
Primary Language:		Social Security #:	<del>_</del>
Phone # where applican	t accepts calls (if any): (	)	
Pager: ( )			
Cell Phone: ( )			
Address:		City/Town:	ZIP:
Place to send mail (if differe	ent):		
City/Town:		ZIP:	
Gender: Male Female_	Transgender		
Race: Hispanic/Latino Other		mericanHaitianAsian_	Native American
Existing Case Managers (ot	her than referring person) a	assisting with HIV-related issues	(optional):
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)* 

Names of individuals who will live with the applicant	Relationship to applicant	Age	Source(S) of income * (Wages, SSI, AFDC, etc.)	Monthly Income*	Annual Income*
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.

Living in a shelter.
Living on the street (having no fixed, regular, nighttime residence).
Living in Department of Transitional Assistance Program.
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.

Living in and receiving care from an institution not designed for long term residence (e.g. hospital, rehabilitation facility etc.)
Doubled up (living temporarily with friends or relatives)
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).
Renting an apartment using a transitional subsidy such as AHVP or DMH.
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.
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.
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).
Rent burdened - paying 75% or more
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: \_\_\_\_\_

Universal Preliminary Application for HIV/AIDS Housing; Revised September, 2004

### I. AUTHORIZATION OF REPRESENTATION/RELEASE OF INFORMATION:

The applicant authorizes that \_\_\_\_\_\_ (Name of Housing Advocate or other representative) is permitted to represent the applicant in the process of applying to this HIV housing opportunity and has permission to release information and receive information related to all matters concerning the applicant in this process. This release may be revoked at any time verbally or in writing.

Applicant Signature:

Date:

#### J. ADDITIONAL COMMENTS: Special Needs

Use this space to briefly note other pertinent information:

## **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,				
Medical Provider Signature         Medical Provider Name Printed         Clinic Name and Address	Date Phone Number			

## CERTIFICATION OF HOMELESSNESS

To be eligible for **Shelter Plus Care** and/or **Supported Housing Programs**, an applicant must be homeless, as defined by HUD. Homeless is defined as living in a shelter or on the streets. An applicant who is residing in transitional housing for less than 2 years is also eligible as long as she/he was homeless according to the above definition immediately prior to entering the transitional housing program. An applicant is also eligible after a stay at a hospital or other inpatient stetting as long as s/he was homeless according to the above definition immediately prior to the inpatient stay. If the inpatient stay was less than 30 days, the applicant should be counted as coming from his/her immediate prior place of stay (street or shelter).

# This form must be filled out by the individual or social service agency that can verify the individual's presence at the checked-off program/setting/institution/shelter

I hereby verify that the referred applicant, \_\_\_\_\_ (Name) is currently: (check only one, and complete related information)

- □ In an emergency shelter.
- □ In a transitional housing program for less than 2 years and was homeless (in a shelter or on the streets) immediately prior to the transitional housing stay.
- □ In an inpatient setting (for less than 31 days) and was living on the streets or in an emergency shelter <u>immediately prior to the inpatient stay</u>.
- □ In an institution (for more than 31 days) and <u>no subsequent residence has been identified and lacks the</u> resources and support network necessary to obtain housing.
- □ In a public/ private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, such as cars, parks, sidewalks, and abandoned buildings. This form may be signed and dated by collateral contacts or by client requesting supportive housing. Other verifying documentation may be presented.
- **Being evicted within a week from a private dwelling unit and <u>no subsequent residence has been identified</u> <u>and the person lacks the resources and support networks needed to obtain housing</u>.** *Please attach a signed and dated letter verifying the eviction proceedings and unsuccessful attempts to secure other housing options***.**

This must be completed <u>except</u> when individual is being evicted

Name or location of program/institution/setting/shelter:

Date entered program/setting/institution/shelter: \_\_\_\_/ /\_\_\_\_/

Location prior to this stay:

I understand that false statements or information are punishable under Federal Law.

Signature of Authorized Program Staff

Print Name of Authorized Program Staff

Program/Agency Name

## **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 apartmentdoubled uptransitional program	shelterother:	
Landlord/other contact name:	Phone:	
May we call this person for a reference? YesNo		
Applicant's address:	Lived here from	to .
Type of residence: rented apartment doubled up transitional program		
Landlord/other contact name:	Phone:	
May we call this person for a reference? YesNo		
Applicant's address:	Lived here from	to
Type of residence:rented apartmentdoubled uptransitional program	_shelterother:	
Landlord/other contact name:	Phone:	
May we call this person for a reference? YesNo		
Applicant's address:	Lived here from	to
Type of residence:rented apartmentdoubled uptransitional program	shelterother:	
Landlord/other contact name:	Phone:	
May we call this person for a reference? YesNo		
Applicant's address:	Lived here from	to
Type of residence:rented apartmentdoubled uptransitional program	shelterother:	
Landlord/other contact name:	Phone:	
May we call this person for a reference? YesNo		
(Use additional page if necessary)		