Tenant Based Rental Assistance Intake Application

THIS IS A MONTH TO MONTH PROGRAM

Attention: A COMPLETE application includes the following attachments:

1. Proof of HIV status **2. Advocacy Letter** **3. Background Check** **4. Proof of Income (Last Two Months)**

5. Lease (W9 If Applicable) **6. Copy ID/SS Card** **7. TB Clearance** **8. Current ISP (Signed/Dated)**

9. Housing Goals **10. Budget Worksheet**

Name of Applicant____

Address____

City ________________________**State** ______ **Zip**_______________ **County** _______________________

Social Security # ___________________________**Date of Birth**___________________________________

Daytime Phone # ___________________________**Other Phone#** _________________________________

Additional household members, use back of sheet if necessary:

Name	Relationship	Age / Date of Birth / Sex M/F

Total Household Size _____________

Total combined ANNUAL household income $______________________

(Income of a live -in caregiver is not included in household income. If a caregiver is included in the household, include a copy of the physician's order that a live-in caregiver is required, and a copy of the caregiver's employment agreement with the hiring agency.)

HIV status of applicant: ___HIV non-symptomatic ___HIV symptomatic ___Disabling HIV ___AIDS

Signature ____________________________________ **Date:** __________________

(Case Manager)

Agency: ______________________________________ **Phone#** ________________

RELEASE OF INFORMATION / MEDICAL VERIFICATION FORM

My signature below authorizes my Health Care provider and Living Room to release and share information contained in my medical records regarding the status of my health, including HIV verification, mental health and screen for illegal drugs. I understand that the release of this information is for the sole purpose of my ability to obtain housing and will not be used for any other purpose unknown to me.

Name of Client____ **Date of Birth** ______________________________

Social Security Number_____________________ **Medical record number (if applicable)**______________________

____

Client Signature **Date**

____

Witness Signature **Date**

THIS INFORMATION MUST BE COMPLETED AND SIGNED BY THE CLIENT'S HEALTH CARE PROVIDER

Medical Provider Information:

Name of health care provider____**Phone**___________________

Name of health care facility ____

Address ____**Phone #** _____________________

Diagnosis: ( )HIV+ ( )AIDS **T-Cell/CD4 count**_________ **Date**____________________
Viral Load ______________ **Date**____________________
( ) TB (within 1 year) Results__________________ **Date**____________________
( )Chest x-ray (if required) Results__________________ **Date**____________________
( ) Sputum (if required) Results__________________ **Date**____________________

Most Recent health concern_____________________________________ **Date**____________________

Is the patient compliant with prescribed treatment and medication? ( )Yes ( )No ( )Unknown
Activities of Daily Living
( ) Fully able to completely care for self (Bathe, dress, feed self, prepare meals)
( ) Able to perform moderate physical activities for ________ Hours per day
( ) Needs assistance with activities of daily living
( ) Bed and chair-confined to room
( ) Bedridden most of the time

Mental Status
( ) Normal
( ) Moderately Impaired
( ) Severely impaired

Comments on Mental Status____
____
____
____

Has the person ever had a mental health assessment? ( )Yes ( )No
If Yes, what was the diagnosis?____
Is he/she current on any mental health meds? ( )Yes ( )No **Self-administered? ( )Yes ( )No**

Please list medications____

____

Provider name and title (Please Print) **Provider signature** **Date**

To be completed by Applicant:

I hereby affirm the enclosed information is true and complete to the best of my knowledge. I understand that any misrepresentation or omission will be grounds for the cancellation of my application and/or housing assistance.

I understand that Living Room, Inc. may need to contact individuals or agencies to verify the above information. I further understand that my signature below services as a time-limited consent to contact any individuals or agencies who can verify and support my ability to succeed in the TBRA program. I may revoke my consent at any time in writing and, if not earlier revoked, it shall terminate upon my exit from the program.

I understand that if I am found to be eligible for TBRA, I will need to allow the staff to conduct a Housing Quality Standards (HQS) inspection of the rental unit for which I am seeking assistance. This inspection will focus on health, safety, and accessibility issues. I understand that failure of the unit to pass HQS will not make me ineligible for the program, but may require that changes or improvements be made to the unit in order for me to receive rental assistance.

I understand that TBRA is sponsored by Living Room, Inc. and is funded with federal Housing Opportunities for People with AIDS (HOPWA) funds and that my participation in the program is based, in part, on my HIV status. I further understand that, while all participating agencies will adhere to all legal requirements to protect my confidentiality, my participation in the program may cause my HIV status to be inferred by others who become aware of my participation.

I understand that if I have provided any false information, this may disqualify me for participation in TBRA. This application has been completed, and read by or to me, prior to signature.

Warning: Section 001 of Title 18 of the U.S. Civil code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the U.S. Government as to any matter within its jurisdiction.

Note: All information must be complete and accurate for consideration. This is not an entitlement program. This application does not guarantee housing assistance of any kind.

Applicant Signature: __________________________________ Date: __________________________

For Statistical purposes only:

This information is required by the United States Department of Housing and Urban Development for statistical purposes. It does not in any way effect your eligibility for housing assistance in TBRA.

1. Age and gender of persons in household.

Persons	Male	Female
A. 17 years and under		
b. 18 - 30 years		
c. 31 - 50 years		
d. 51 - years and older		

2. How many household members are in the following ethnic categories?

a. Hispanic	
b. Non-Hispanic	

3. How many household members are in the following racial categories?

a. Asian/Pacific Islander	
b. Black	
c. Native American or Alaskan Native	
d. White	

PSYCHIACTRIC HOSPITALIZATIONS

INSTITTUTION	DATES/LENGTH OF STAY	REASON FOR ADMISSION

MEDICAL HOSPITALIZATIONS

INSTITTUTION	DATED/LENGTH OF STAY	REASON FOR ADMISSION

<u>RISK ASSESMENT</u>

History of Substance Abuse & Treatment

Drug (s) of choice

( ) Cocaine ( ) Heroin/Opiates ( ) Marijuana ( ) Other
( ) Crack ( ) Alcohol ( ) Prescription Drugs
( ) IV Drugs ( ) Benzodiazepines ( ) Over the Counter Drugs/Inhalants
( ) Sedatives ( ) Amphetamines ( ) PCP

How many times did you use in the past week, past month?____

Drug & Alcohol Rehab Admissions

INSTITTUTION	DATES/LENGTH OF STAY	COMPLETED Y/N

Current Groups, Self-Help and Other support	**Desired Support system**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

MENTAL HEALTH & CASE MANAGEMENT SERVICES

Counseling/Treatment Services	Agency: Address: Counselor/Therapist: Telephone: Upcoming appointments:
Prescribing Psychiatrist	Agency: Address: Psychiatrist: Telephone: Upcoming appointments:
Case Management/ Care Coordination	Agency: Address: Manager/Coordinator: Telephone: Frequency of Contacts:

CURRENT PSYCHOTROPICAL MEDICATIONS

MEDICATIONS	DOSAGE	FREQUENCY

Ability To Self Medicate & History of Compliance: