Shelter+Care

Application for Housing Assistance

1. Name: _____

1a. **Maiden Name or previous names** (if applicable) _____

2. Gender: ____ Male ____ Female

3. Social Security Number: _____-_____-_____

4. DOB: _____

5. Mailing Address: _____

6. Telephone Number: _____

7. Primary Disabilities: *(Information below should match Disability Verification form.)*

____ Severe mental illness (SMI) ____ AIDS-related disease.

____ Chronic alcohol abuse ____ Chronic drug abuse ____ Other. Specify: _____

8. Current Housing: *(Attach living situation verification written on agency letterhead stating location, length of stay and date of homelessness, include title of person completing the verification.)*

____ Living in a place not designed for habitation. Specify: _____ Length of stay:___ days

____ Living in emergency shelter or hotel with emergency funds Length of stay:___ days

____ Transitional housing for homeless persons **Program Name**: _____ Length of stay:___ days

____ Domestic Violence Situation Length of stay:___ days

____ Other*: Specify: _____ Length of stay:___ days

**Please note eviction proceedings and living with family and friends do not meet the qualification guidelines for Shelter Plus Care*

9. How many separate times have you been *on the streets or in a shelter* in the past 3 years?

(*Attach verification if you want to be considered for chronic homeless funding)*

(Do not report times when you were staying with friends/relatives)

10. Correspondence: Do you want us to copy all correspondence (i.e. acceptance letter, denial letter, debt information) to your referral source or other service provider? If yes, please provide name, address and phone number

Payee: ____ Yes ____ No _____

Service Provider: ____ Yes ____ No _____

11. Have you applied to a subsidy program before? ____ Yes ____ No If yes, where _____

If yes, what was the outcome of your application?

____ Denied

____ Accepted but no housing unit was found

____ Housed

12. Household Information:

A. Size: _____

B. Household Members who will be **residing** in unit (Please include applicant):

Name:	Relationship to Applicant:	DOB	Pregnant:
_____	_____	_____	__ Yes __ No
_____	_____	_____	__ Yes __ No
_____	_____	_____	__ Yes __ No
_____	_____	_____	__ Yes __ No
_____	_____	_____	__ Yes __ No

13. Income & Other Assistance Sources

Income Sources:	*Monthly Amount:*	*Other Assistance Sources:*
___ No financial resources	$_____	____ None
___ Supplemental Security Income (SSI)	$_____	____ Food Stamps
___ Social Security Disability Income (SSDI)	$_____	____ Medicare
___ Social Security	$_____	____ MaineCare
___ Employment income	$_____	____ Children's State Health Prgm (SCHIP)
___ General Public Assistance (GA)	$_____	____ Veterans Health Care
___ Unemployment benefits	$_____	____ WIC Insurance
___ Temporary Aid Needy Families (TANF)	$_____	____ Other: Specify: _____
___ State Supplement	$_____	
___ Other: Specify: _____	$_____	
TOTAL INCOME:	$_____	

14. Are you receiving now, or willing to accept support services? ____ Yes ____ No
Current services and providers (*include contact persons and telephone number*):

_____

_____

_____

_____

_____

Shelter Plus Care (S+C) is required to participate in the statewide Homeless Management Information System (HMIS). Participation in the S+C program means your information will be submitted to a secure database so that Maine can generate mandated federal reports about homelessness.

All application information is true and correct to the best of my knowledge. I give my consent to release the above information to persons or agencies involved with the Shelter+Care Program for the purpose of determining program eligibility, as well as coordination of locating an apartment, calculating housing assistance, and providing appropriate services.
This consent will automatically expire in one year or on _____.

_____ _____
Applicant Signature *Date*

_____ _____
Guardian Signature (If applicable) *Date*

Guardian Address & Phone Number: _____

****

Prepared/Reviewed by: _____
Please sign name and credentials

Agency: _____ **Telephone:** _____

****

LAA OFFICE USE ONLY

Application Completed On: ___/___/____

Was applicant accepted into program: ___Yes ___No If denied, please complete section below:

____ Not disabled ____ Did not have disability served by the project ____ Not homeless ____ No vacancies

____ Other Specify: _____ Refused to participate Specify reason: _____

Conditions of Acceptance: _____

_____

Other Comments: _____

_____

Local Administrative Agency:_____

_____ _____
S+C Representative Signature **Date**

S+C grant : _____ **Slot assigned:** _____/_____/_____ **Slot Size:** _____

Date Housed in S+C: _____/_____/_____ **S+C Worker Assigned:** _____

SHELTER + CARE PROGRAM
DISABILITY VERIFICATION FORM

INSTRUCTIONS:
A qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP, Psychologist) must complete this form. LADC staff may complete this form only for applicants with a qualified substance abuse disability.
Sections 1, 2 and 3 of the form apply to:

Name:_____ **DOB:**_____

SECTION 1: APPLIES TO INDIVIDUALS WITH PSYCHIATRIC DISABILITIES, CHRONIC SUBSTANCE ABUSE AND HIV/AIDS
The above named individual is an adult having a physical, mental, or emotional impairment that:

(a) is expected to be of long-continued and indefinite duration
AND
(b) substantially impedes the person's ability to live independently
AND
(c) is such that the person's ability to live independently could be improved by more suitable housing conditions.

If a, b, and c above are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

SECTION 2: APPLIES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES
The above named individual is an adult with a chronic and severe developmental disability which:

(a) is attributable to a mental and/or physical impairment or combination mental and physical impairments; **AND**

(b) was manifested before the person attained age 22; **AND**

(c) is likely to continue indefinitely; **AND**

(d) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency; **AND**

(e) reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong, or extended duration and are individually planned and coordinated.

If a, b, c, d and e above are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

SECTION 3: Applies to all applicants

The individual named above is an individual with (a): (Check all that apply)

☐ Psychiatric Disability
☐ HIV/AIDS
☐ Other Disability _____
☐ Chronic Alcohol Abuse
☐ Chronic Substance Abuse

_____ _____
Name and credentials of Provider Agency and Telephone Number

_____ _____
Signature Date

SHELTER + CARE PROGRAM
VERIFICATION OF DISABILITY FORM

DATE: _____

TO: _____ **FROM:** _____

_____ _____

_____ _____

_____ _____

_____ has applied for housing assistance under the Shelter + Care program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the verification of all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in completing the attached form and returning as quickly as possible to the provider listed above. Your prompt return of this information will help assure timely processing for housing assistance. Enclosed is the release completed by the applicant consenting to the release of information about their disability.

Please do not hesitate to call with any questions or concerns.

Sincerely,

Penalties for misusing the consent: Title 18, Section 1001 of the US Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the US Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willing requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42 USC 208(f)(g) and (h). Violations of these provisions are cited as violations of 42 USC 208(f)(g) and (h).