

SUBMITTING YOUR COMPLETED APPLICATION

For more information or to submit a completed application, please contact one of the following agencies depending on County preference.

**ANDROSCOGGIN, FRANKLIN, AND OXFORD COUNTIES**

**Common Ties**

P.O. Box 1319

Lewiston, ME 04243

Tel. 207-795-6710                      Fax: 207-795-6714 (Attn: Housing)

**YORK, CUMBERLAND, KNOX, LINCOLN, SAGadahOC, AND WALDO COUNTIES**

**Shalom House, Inc.**

106 Gilman Street

Portland, ME 04102

Tel. 207-874-1080                      Fax: 207-874-1077 (Attn: BRAP)

**AROOSTOOK, HANCOCK, PENOBSCOT, PISCATAQUIS, AND WASHINGTON COUNTIES**

**Community Health & Counseling Services**

P.O. Box 425

Bangor, ME 04402-0425

(42 Cedar Street, Bangor, ME 04401)

Tel. 207-947-0366

**KENNEBEC AND SOMERSET COUNTIES**

**Kennebec Behavioral Health**

67 Eustis Parkway

Waterville, ME 04901

Tel. 207-873-2136                      Fax: 207-660-4532

**BRIDGING RENTAL ASSISTANCE PROGRAM (BRAP)  
APPLICATION**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Gender:**  Male  Female  Transgender MTF  Transgender FTM  Gender Non-Conforming

**Social Security Number:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Veteran:** YES  NO

**Are you Hispanic or Latino?**  Yes  No

**Race (check all that apply):**

American Indian or Alaskan Native  
 Black or African-American  
 White or Caucasian

Asian  
 Native Hawaiian or Pacific Islander  
 Other: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Preferred Counties (1<sup>st</sup> & 2<sup>nd</sup> choice):** \_\_\_\_\_

**1. Is the applicant an AMHI Consent Decree Class Member?** YES  NO

\*(A Consent Decree Class Member is someone who was hospitalized at AMHI/Riverview Psychiatric Center on, or after January 1, 1988.)

**2. Does Applicant meet Eligibility For Care for Community Support Services?**

\*(As defined in Section 17 of the MaineCare Benefits Manual effective 4/08/2016) YES  NO

*\*If you answered 'no' to questions #1 and #2 you are not eligible for assistance under BRAP*

**3. Is the applicant currently receiving SSI or SSDI (Attach documentation dated within 120 days of application date)?** YES  NO

**4. If no, are you in the process of applying for or appealing SSI or SSDI (Attach documentation of application or appeal)?** YES  NO

*\*If you answered 'no' to questions #3 and #4 you are not eligible for assistance under BRAP*

**5. Is applicant currently on a waitlist for federally subsidized housing?** YES  NO

**5A. If 'No' why?** \_\_\_\_\_.

**\*\*ATTACH VERIFICATION FROM THE HOUSING AUTHORITY OR MANAGEMENT COMPANY WHERE YOU APPLIED FOR SUBSIDIZED HOUSING AND/OR SECTION 8.**

**6. 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 for all that apply.

Payee:           **YES**     **NO**  \_\_\_\_\_

Case Manager:   **YES**     **NO**  \_\_\_\_\_

Guardian:       **YES**     **NO**  \_\_\_\_\_

Service Provider: **YES**     **NO**  \_\_\_\_\_

**7. Household Composition:** Please list everyone who will be residing in the household.

*\*Please note: Each additional Household Member must complete and attach a Household Member Form*

<u>Name:</u>	<u>Relationship to Applicant:</u>	<u>Pregnant:</u>
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

**8. Applicant Income & Other Assistance Sources:**

*Documentation of current monthly income must be attached.*

**Income Sources**

No financial resources                                   \$ \_\_\_\_\_

Supplemental Security Income (SSI)               \$ \_\_\_\_\_

Social Security Disability Income (SSDI)           \$ \_\_\_\_\_

Social Security    \$ \_\_\_\_\_

Employment income                                     \$ \_\_\_\_\_

General Public Assistance (GA)                     \$ \_\_\_\_\_

Unemployment benefits                               \$ \_\_\_\_\_

Temporary Aid Needy Families (TANF)           \$ \_\_\_\_\_

State Supplement                                        \$ \_\_\_\_\_

Other (Source): \_\_\_\_\_                           \$ \_\_\_\_\_

**Other Assistance Sources**

None

SNAP / Food Stamps

Medicare

Medicaid (MaineCare)

SCHIP

VA Medical Services

WIC

TANF (Child Care / Transp.)

Indian Health Services

Employer Provided Insurance

Other (Source): \_\_\_\_\_

**TOTAL Monthly INCOME:**                           \$ \_\_\_\_\_

**9. Please indicate priority and ATTACH VERIFICATION for all that apply:**

**Priority 1**

**Psychiatric Discharge:** BRAP Applicants who are being discharged from Riverview Psychiatric Center or Dorothea Dix Psychiatric Center, private psychiatric hospitals, or who have been discharged in the past thirty (30) days and were admitted to a Psychiatric facility for a period greater than seventy-two (72) hours. Also, BRAP Applicants who are moving from Community Residential Treatment Programs, 10-144 C.M.R. Ch. 101 MaineCare Benefits Manual, Ch. II Section 97, Appendix E, to less restrictive accommodations, to allow for appropriate discharges, as determined by the clinical team from the institutions mentioned above. *Intake and/or discharge paperwork from institution or program referenced above with a clear intake and discharge date must be attached.*

- Applicant is being discharged from a State Psychiatric Hospital (RPC or DDPC) after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;
- Applicant is being discharged from a private psychiatric hospital after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;
- Applicant is moving from a Community Residential Treatment Program (Mental Health PNMI), to less restrictive accommodations to allow for appropriate discharges, as determined by the clinical team from the institutions mentioned above;
- Applicant has been discharged within the past thirty (30) days from a State Psychiatric Hospital (RPC or DDPC) after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;
- Applicant has been discharged within the past thirty (30) days from a private psychiatric hospital after a seventy-two (72) hour or greater psychiatric inpatient hospital admission.

**Priority 2**

Applicant is being released within the next thirty (30) days from a Correctional Facility and meets Section 17 criteria; or Applicant has been released within the past thirty (30) days from a Correctional Facility and meets Section 17 criteria; or Applicant has been adjudicated through a Mental Health treatment court and meets Section 17 criteria, who have no subsequent residences identified. *Intake and/or release paperwork from Correctional Facility referenced above on agency letterhead stating Correctional Facility, dates of stay, and include the title of the person completing the verification must be attached.*

- Is being released within the next thirty (30) days from a Correctional Facility and no subsequent residences have been identified;
- Has been released within the past thirty (30) days from a Correctional Facility and no subsequent residences have been identified;
- Has been adjudicated through a Mental Health treatment court and documentation is attached.

### Priority 3

Applicant is Literally Homeless, as defined by HUD. Applications received are on a ranked basis according to length of homelessness, with those being homeless the longest as the top priority. *Verification of current living situation typed on agency letterhead stating current living situation, length of stay and dates of homelessness; include title of person completing the verification. The last documented incidence must be dated within 14 days of application submission. Please note: Eviction proceedings and living with family and/or friends does not meet the qualification guidelines for literal homelessness.*

- Chronic Homelessness: Documented Literal Homelessness (homeless continuously for at least 365 days or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months);or*
- Long Term Stayer: Documented Literal Homelessness (180 nights of past 365 days);*
- Living in a place not designed for habitation such as cars, parks, sidewalks, and abandoned or condemned buildings. This may include persons who ordinarily sleep in one of the above places but are spending a short time (90 consecutive days or less) in a hospital or other institution;
- Living in an Emergency Shelter or hotel/motel with emergency funds;
- Living in Transitional Housing for homeless persons (*verification of homelessness prior to program entry must be attached.*)

#### Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.



Applicants are encouraged but not required to engage in services as a condition of acceptance into the Bridging Rental Assistance Program.

**10. CERTIFICATIONS:**

\_\_\_\_\_ **Initials** Any previous BRAP/SPC recipient may re-apply for subsidy, as long as he or she is eligible and in good standing with any housing subsidy program administered by DHHS (Bridging Rental Assistance Program &/or Shelter Plus Care). Applicants, who owe any DHHS administered housing subsidy program for back rent, damages, security, etc., may be considered for readmission providing that one of the following minimum criterions have been met:

- 100% of account balance must be paid before move in and/or unit transfer; or
- Establishment of a Representative Payee and a documented payment plan not to exceed 12 months

*Failure to meet at least one of the above criterions may result in program in-eligibility.*

\_\_\_\_\_ **Initials** Section 8 compliance: I understand that one of the eligibility criterion for BRAP is that I must maintain an active application for federally assisted housing during my entire tenure with BRAP, with a local Public Housing Authority or Administrator. If a wait list is closed, I understand that I am obligated to get on the list at the earliest opening date. I understand that if I do not comply with this and other requirements detailed in the Tenant Responsibility Agreement, I may be immediately terminated from BRAP.

\_\_\_\_\_ **Initials** Release of Information: I/We agree to complete the necessary release(s) of information which will allow \_\_\_\_\_ (Name of LAA) to obtain, verify, and document information pertaining to initial and ongoing eligibility for rental assistance provided under this program.

\_\_\_\_\_ **Initials** Release of information: I/we agree to have any and all correspondence relating to initial and ongoing eligibility for rental assistance copied to my guardian and/or representative payee and/or other designated person as identified in Question 6.

\_\_\_\_\_ **Initials** Tenant’s Certification: I/We certify that the information contained in this application is true and complete to the best of my/our knowledge and belief. Failure to furnish true, accurate, and complete information, now or in the future, will result in one or more of the following: termination from program, eviction, formal investigation, legal action. Intentionally submitting false or incomplete information, including but not limited to submitting false household income and/or composition, is a crime.

\_\_\_\_\_ **Initials** If you were homeless prior to enrolling in BRAP: The Bridging Rental Assistance Program you are a participant in the statewide Homeless Management Information System (HMIS). Participation in the BRAP program means your information and the information of your household members will be submitted to a secure database so that Maine can generate mandated federal reports about homelessness.

Print Applicant Name	Applicant Signature	Date
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Print Name–Other Adult Member	Other Adult Member Signature	Date
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**ELIGIBILITY VERIFICATION**

- 1. I hereby affirm the above-enclosed information concerning current housing situation, current address, and eligibility criteria are true and accurate for this client as indicated above; and
- 2. I verify the Applicant meets the Eligibility For Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual or is already enrolled in PNMI services:

CHECK APPROPRIATE BOX and ATTACH VERIFICATION:

- i.  Applicant is already enrolled in Adult Mental Health Services funded Community Support (Section 17) and/or PNMI services (Section 97)—verification of enrollment with KEPRO HealthCare or DHHS attached; **OR**
- ii.  No KEPRO HealthCare or DHHS Adult Mental Health Enrollment form is currently on file. I have attached a completed BRAP Enrollment Form to provide a mental health diagnosis or have attached such a signed qualifying diagnosis my agency deems appropriate to document eligibility for services under Section 17 as may be approved by KEPRO HealthCare and/or DHHS to the BRAP Enrollment Form.

Referring Agency: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**LAA OFFICE USE ONLY**

**Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program:** \_\_\_\_\_ **Slot assigned:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Slot Size:** \_\_\_\_\_

**Date Housed in program:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Worker Assigned:** \_\_\_\_\_

**Office of Adult Mental Health Services**  
**BRAP ENROLLMENT FORM**

**To be completed ONLY for persons not already Enrolled in Section 17 Services AFTER April 7, 2016**

**Client Information:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Diagnosis and LOCUS Information:**

Primary Diagnosis: \_\_\_\_\_

Date Given: \_\_\_\_\_

LOCUS Score: \_\_\_\_\_ Rater ID: \_\_\_\_\_

Date Given: \_\_\_\_\_

**Requirements for Eligibility.** A person is eligible to receive covered services if he or she meets both general MaineCare eligibility requirements and specific eligibility requirements for Community Support Services under Section 17 of the MaineCare Benefits Manual.

**General Requirements.** Individuals must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

**Risk Factors:** Documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis.

**Specific Requirements.** A member meets the specific eligibility requirements for covered services under this section if:

- A.** The person is age eighteen (18) or older or is an emancipated minor with:
1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
  2. Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:
    - a) has a written opinion from a clinician, based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or
    - b) has received treatment in a state psychiatric hospital, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - e) has been committed by a civil court for psychiatric treatment as an adult; or
    - f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

**AND**



- B. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.
- C. Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both.
- D. The LOCUS or other approved tools must be administered, at least annually, or more frequently, if DHHS or an Authorized Entity requires it.

**History Of (check all which apply):**

- Has received treatment in a state psychiatric hospital, within the past 24 months;
- Has been discharged from a mental health residential facility, within the past 24 months;
- Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months;
- Has been committed by a civil court for psychiatric treatment as an adult;
- Until the age 21, the recipient was eligible as a child with severe emotional disturbance.\*

\* If selecting this qualifier, please indicate a written opinion stating that the recipient, in the last 12 months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

**Based on documented or reported history\*\*, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of (check all which apply):**

- Homelessness;
- MH Residential treatment;
- MH inpatient greater than 72 hours;
- Criminal Justice involvement.

\*\* Reported history may include oral or written history from the client, a provider, or a caregiver

**Signatures and Certifications:**

I, \_\_\_\_\_, certify and attest that the diagnostic information listed on the previous page (7) are in accordance with the Specific Requirements section of this form (Part A, paragraph 2, sub-paragraph a) and is true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Print Name and Credentials (must be MD, LCSW, LCPC, PhD, APRN, NPC, PA or DO)

Date: \_\_\_\_\_

## Maine's HMIS Authorization to Disclose Information

Agency: \_\_\_\_\_

For: \_\_\_\_\_

Print First, Middle, and Last Name (Complete one form for each adult)

\_\_\_\_\_

Date of Birth

Children/Incapacitated Persons: \_\_\_\_\_

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Date of Birth

Your personal information is confidential. We and anyone with access to the information we collect from you must keep your information confidential and protect the information under strict safeguards. Your personal information and that of the above listed persons for whom you have authorization to sign will be collected by the above Agency and entered into Maine's Homeless Management Information System (HMIS). With your consent, your personal information, including historical information in HMIS, will be made available to other agencies providing services to you through HMIS.

A list of agencies participating in HMIS that may have access to your information if you sign this authorization is at [www.mainehmis.org](http://www.mainehmis.org) and available from Agency.

### Why disclose your information to other agencies?

- Sharing reduces the amount of time you have to spend answering basic questions about your situation.
- Sharing allows agencies to focus on meeting your unique needs quickly.
- Sharing makes it easier for multiple agencies to coordinate housing and services for you and your family.

### What information might be disclosed to other agencies?

Family/Household

Information

Name, birthdate, Social Security Number

Gender, race, ethnicity

Reasons for seeking services

Living situation and housing history

Services you receive

If you are homeless or not

Your income and income sources

Disabling condition(s)

Public benefits you receive

History of domestic violence

Educational background

Employment information

Military history

Health information, including physical health, HIV, behavioral health (mental health and substance use disorder information)

Please check (✓) a box:

**DISCLOSE(Share):** I consent to have the information collected by Agency about me and historical information about me already in HMIS disclosed through Maine's HMIS to other partner agencies in order to improve services to me and the services offered to others. I intend that this authorization permit Agency to disclose through the HMIS system any HIV, mental health and substance abuse or substance use disorder information Agency may collect about me. Maine law requires us to tell you that releasing HIV information may have implications. Release of HIV information may help us better serve you. However, misuse of the information could result in discrimination.

This consent does not apply to any information collected by Milestone Recovery, Shaw House, New Beginnings (not including 169 Holland Street), Preble Street (only Joe Kreisler Teen Shelter or youth related project), any Runaway and Homeless youth program or any victim service provider.

**DO NOT DISCLOSE:** I do **not** want **any** of the information collected by Agency about me disclosed (shared) to any other agencies through Maine's HMIS. I understand that not disclosing my information to other agencies may affect the ability to quickly and appropriately identify services for me.

## Maine's HMIS Authorization to Disclose Information

**When you sign this form, it shows that you understand the following:**

- You have the right to refuse to sign this authorization.
- **Agency will not** deny you help if you do not want us to disclose your personal information to other agencies. At the same time, disclosing your information does not guarantee that you will receive assistance from the recipient agency.
- If you permit us to disclose your information to other agencies:
  - This consent is valid for 1 year.
  - You have the right to review any mental health information that may be disclosed under this authorization, upon request prior to signing this authorization.
  - You may change your mind and cancel this authorization at any time. If Agency is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, see Agency's HIPAA Notice of Privacy Practices on how to revoke this authorization. If you cancel this authorization, your information will no longer be disclosed from that date forward, except to the extent that your authorization has already been relied upon by Agency or others.
- Subsequent disclosures may be made under this same authorization.
- Your information may be disclosed by someone who receives the information and no longer protected.
- You have the right to receive a copy of this authorization.

\_\_\_\_\_  
SIGNATURE OF CLIENT OR AUTHORIZED  
REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF AGENCY WITNESS

\_\_\_\_\_  
DATE

**Verbal Authorization obtained by phone (Agency Staff Signature):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DHHS SUBSIDY PROGRAMS**  
**BRAP / SPC Household Member Form**

**Instructions:** Please complete a Household Member form for each additional household member who will be residing in the unit.

*\*If form is not completely filled out, the LAA reserves the right to return the application.*

1. **Household Member Name:** \_\_\_\_\_

2. **Program:**      BRAP                    Shelter Plus Care

3. **Relationship to HOH:** \_\_\_\_\_

4. **Gender:**    M    F    Transgender M to F    Transgender F to M    Gender Non-Conforming

5. **Date of Birth:** \_\_\_\_\_     6. **Social Security Number:** \_\_\_\_\_

7. **Are you a Veteran?**    Yes    No

8. **Are you Hispanic or Latino?**    Yes    No

9. **Race (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian                               |
| <input type="checkbox"/> Black or African-American         | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> White or Caucasian                | <input type="checkbox"/> Other: _____                        |

10. **Do you have a Disabling Condition?**    Yes    No

**If yes:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Severe Mental Illness    | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Alcohol Abuse            | <input type="checkbox"/> Drug Abuse          |   |
| <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Physical Disability |   |

11. **Income and Other Assistance Sources:** *Documentation of current monthly income must be attached.*

<i>Income Sources:</i>	<i>Monthly Amount:</i>	<i>Other Assistance Sources:</i>
<input type="checkbox"/> No Financial Resources	\$ _____	<input type="checkbox"/> None
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____	<input type="checkbox"/> SNAP/Food Stamps
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____	<input type="checkbox"/> Children's State Health Program (SCHIP)
<input type="checkbox"/> Social Security Retirement	\$ _____	<input type="checkbox"/> Medicare
<input type="checkbox"/> Employment income	\$ _____	<input type="checkbox"/> MaineCare
<input type="checkbox"/> General Public Assistance (GA)	\$ _____	<input type="checkbox"/> Veterans Health Care
<input type="checkbox"/> Unemployment Benefits	\$ _____	<input type="checkbox"/> Employer-Provided Health Insurance
<input type="checkbox"/> Temporary Aid Needy Families (TANF)	\$ _____	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> State Supplement	\$ _____	<input type="checkbox"/> WIC Insurance
<input type="checkbox"/> Other (Source): _____	\$ _____	<input type="checkbox"/> Other (Source): _____

**TOTAL MONTHLY INCOME:** \$ \_\_\_\_\_

**12. Where are you currently residing?**

- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, tent, camping site, or anywhere outside)
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Safe Haven
- Foster care home or foster care group home
- Hospital (non-psychiatric)
- Jail, prison or juvenile detention facility
- Long-Term Care Facility or Nursing Home
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center
- Hotel or motel paid for without emergency shelter voucher
- Owned by client, no ongoing housing subsidy
- Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- Rental by client, no ongoing housing subsidy
- Rental by client, with VASH housing subsidy
- Rental by client, with other (non-VASH) ongoing housing subsidy
- Staying or living in a family member’s room, apartment or house
- Staying or living in a friend’s room, apartment or house
- Transitional housing for homeless persons (including homeless youth)

Length of Stay: \_\_\_\_\_ | Zip Code: \_\_\_\_\_

**13. If coming from a Homeless Situation:**

How many separate times have you been on the streets or in a shelter in the past 3 years? \_\_\_\_\_

Approximate Date Homelessness Started: \_\_\_\_/\_\_\_\_/\_\_\_\_

**14. Are you a victim or survivor of domestic violence?**  Yes  No

**14a. If yes, when:**

- Within the past three months ago
- From six to twelve months ago
- Don’t Know
- Three to six months ago
- More than a year ago
- Refused to Answer

**14b. If yes, are you currently fleeing?**  Yes  No  Refused

**Tenant’s Certification:** By signing below, I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
APPLICANT or HOUSEHOLD MEMBER (18+) or GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE