Shelter Plus Care
Application for Housing Assistance

1. Name: _____

2. County Preferred: _____

3. Mailing Address: _____

4. Telephone Number: _____

5. Gender: ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Gender Non-Conforming

6. Social Security Number: _____ **7. DOB:** _____

8. Veteran: ☐ Yes ☐ No **9. Are you Hispanic or Latino?** ☐ Yes ☐ No

10. Race (check all that apply):

☐ American Indian or Alaskan Native
☐ Black or African-American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

11. 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 _____
Case Manager: ☐ Yes ☐ No _____
Guardian: ☐ Yes ☐ No _____

12. Disabilities: *(Information below should match Disability Verification form). Please check all that apply.*

☐ Severe mental illness (SMI) ☐ AIDS-related disease ☐ Physical Disability ☐ Brain Injury

☐ Chronic alcohol abuse ☐ Chronic drug abuse ☐ Developmental Disability

☐ Other: Specify: _____

13. Are you a victim or survivor of domestic violence? ☐ Yes ☐ No

13a. If yes, when:
☐ Within the past three months ago ☐ Three to six months ago
☐ From six to twelve months ago ☐ More than a year ago
☐ Don't Know ☐ Refused to Answer

13b. If yes, are you currently fleeing? ☐ Yes ☐ No ☐ Refused

Revised 1/22/2018

14. Current Housing: The U.S. Department of Housing and Urban Development requires documentation of homelessness and disability. *(Please note: Verification of current living situation stating location, length of stay and dates of homelessness on agency letterhead must be attached)*

☐ Chronically Homeless: Documented Literal Homeless (Homeless continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where combined occasions total at least 12 months)
☐ Long Term Stayer: Documented Literal Homeless (*180 nights out of the past 365 days*)

☐ Living in a place not designed for habitation

☐ Living in emergency shelter or hotel with emergency funds

☐ Transitional housing for homeless persons

☐ Victim of Domestic Violence Situation

☐ Other*: Specify:_____

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

15. Household Composition: # of Household Members who will be residing in the unit: _____
Please note: Each additional Household Member must complete and attach a Household Member Form

Name:	Relationship to Applicant:	Pregnant:
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

16. Applicant Income & Other Assistance Sources: *Documentation of current monthly income must be attached.*

Income Sources		**Other Assistance Sources**
No financial resources	$_____	☐ None
Supplemental Security Income (SSI)	$_____	☐ SNAP / Food Stamps
Social Security Disability Income (SSDI)	$_____	☐ Medicare
Social Security	$_____	☐ Medicaid (MaineCare)
Employment income	$_____	☐ SCHIP
General Public Assistance (GA)	$_____	☐ VA Medical Services
Unemployment benefits	$_____	☐ WIC
Temporary Aid Needy Families (TANF)	$_____	☐ TANF (Child Care / Transp.)
State Supplement	$_____	☐ Indian Health Services
Other (Source): _____	$_____	☐ Employer Provided Insurance
		☐ Other (Source): _____
TOTAL Monthly INCOME:	$_____	

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 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:** _____

****

OFFICE USE ONLY

Application Completed On: ___/___/____

Was applicant accepted into program: ___Yes ___No

Was applicant verified as chronic homeless: ___Yes ___No

Was applicant verified as a Long Term Stayer: ___Yes ___No

If denied, please describe reason: _____

Other Comments: _____

_____

Local Administrative Agency:_____

_____ _____

Representative Signature **Date**

Grant: _____ **Slot assigned:** /_____/_____ **Slot Size:** _____

Date Housed in program: _____/_____/_____ **Worker Assigned:** _____

Revised 1/22/2018

DISABILITY VERIFICATION FORM

INSTRUCTIONS:
A qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP, PA, Psychologist; or any other person Licensed by the State of Maine to diagnose and treat persons with the conditions listed below) must complete this form. For example, LADC staff may complete this form only for applicants with a qualified substance abuse disability.

Name:_____ **DOB:**_____

SECTION 1: APPLIES TO INDIVIDUALS WITH PSYCHIATRIC DISABILITIES, CHRONIC SUBSTANCE ABUSE (alcohol or drug abuse), POST-TRAUMATIC STRESS DISORDER, BRAIN INJURY, AND HIV/AIDS

A person shall be considered to have a disability if he or she has an 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) could be improved by more suitable housing conditions **AND**
(d) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury.

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

SECTION 2: APPLIES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

The above named individual has 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 individual's need for a combination and sequence of special interdisciplinary or generic services, individualized support, or other forms of assistance that 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

OR

(f) An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, maybe considered to have a developmental disability without meeting three or more of the criteria described in the above paragraphs through the definition of ''developmental disability'' in this section if the individual, without services and supports, has a high probability of meeting these criteria later in life.

If f, please check 'Yes' or '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
☐ Post-Traumatic Stress Disorder
☐ Developmental Disability
☐ Other Disability _____
☐ Chronic Alcohol Abuse
☐ Chronic Substance Abuse
☐ Brain Injury
☐ Physical Disability

_____ _____
Name and Credentials of Provider Agency and Telephone Number

_____ _____
Signature Date

Revised 1/22/2018

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 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):

☐ American Indian or Alaskan Native
☐ Black or African-American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

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

If yes:

☐ Severe Mental Illness
☐ Alcohol Abuse
☐ Chronic Health Condition
☐ HIV/AIDS
☐ Drug Abuse
☐ Physical Disability
☐ Developmental Disability

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

Income Sources:	*Monthly Amount:*	*Other Assistance Sources:*
☐ No Financial Resources	$_____	☐ None
☐ Supplemental Security Income (SSI)	$_____	☐ SNAP/Food Stamps
☐ Social Security Disability Income (SSDI)	$_____	☐ Children's State Health Program (SCHIP)
☐ Social Security Retirement	$_____	☐ Medicare
☐ Employment income	$_____	☐ MaineCare
☐ General Public Assistance (GA)	$_____	☐ Veterans Health Care
☐ Unemployment Benefits	$_____	☐ Employer-Provided Health Insurance
☐ Temporary Aid Needy Families (TANF)	$_____	☐ Indian Health Services
☐ State Supplement	$_____	☐ WIC Insurance
☐ Other (Source): _____	$_____	☐ 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
- ☐ Three to six months ago
- ☐ From six to twelve months ago
- ☐ More than a year ago
- ☐ Don't Know
- ☐ 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**