

FOR OFFICE USE ONLY:		DATE
Received completed, signed, dated application (inc applicant self-certification & housing history signed/dated)		
Homelessness status verified		
Income Verification (pay stub, SSI/SSD statement, PA budget/statement) is within S+C limits		
Disability Verification (Licensed clinician's diagnosis & signature on application, recent eval, Agency Diagnosis Sheet)		
Date reviewed by HARS Committee:	Decision:	
Placed on waiting list:	Preference given for Chronic Homelessness? Y or N	

Referral For: Shelter Plus Care Program Shannon's House
 Rapid Re-Housing Program MHAB
 Evergreen Townhouse Community

Basic Information

Name: Last First MI Application Date:

Previous names:

DOB: Age: Sex: Male Female SSN:
 Ethnicity: Primary Language: Marital Status:
 (Optional) (Optional)
 Address: City: State:
 Phone(s):

Financial information / sources of income

Employment: Net pay _____ per week / 2 weeks / month / year (circle one)
 SSI SSD Public Assistance VA Alimony Child support Retirement income
 Other income (Describe source and amount) _____
 (If applied and not yet receiving a potential source of income, please describe & give date of application)

Existing Rep. Payee? No Yes (Name, address, phone #)

Health Plan

Medicaid Number: _____ Medicare Number: _____
 Other plan: _____ Number: _____

Emergency Contact Information

Name: Relationship:
 Address: Tel. No.
 City: State: Zip Code:

Referral Information

Person making the referral (name & title):
 Representing which agency / committee:
 Address: City: State: Zip Code:
 Phone: Fax: Email:
 Relationship to recipient:

Mental Health Information

DSM Diagnosis:

Diagnosed by: _____ Date: _____
Print Name & credential Signature

Agency Name:

Address:

Phone/Fax #:

Drug / alcohol use / abuse (What? When? Current or past use? Extent of use? Addicted?)

Recent deterioration of functioning? (Describe):

Other disabilities or medical problems (describe below)	Unknown	Not Present	Mild	Moderate	Severe
Mental retardation					
Other developmental disability / delay					
Learning disabilities not accounted for by developmental delays					
Brain damage due to traumatic brain injury					
Physical handicap					
Severe or disabling medical conditions					
Other (describe)					

Current mental health treatment? (Where, with whom?) (Medications?) (Compliance?)

Mental Health treatment history (Where? Dates? For how long? Why?)

Does this person a history of poor compliance with mental health services, please describe here.

Other Information

Medical information: Describe any significant current medical conditions and treatment being received

Current Living Arrangements
Household Composition (name, Age, relationship to client)

Describe the current physical living space (e.g. apartment, house, etc.) and any problems with living conditions.

Has this person ever had problems in past housing (e.g. eviction, inability to live alone, failure to pay rent?) No Yes, describe.

Legal Concerns (Describe any involvement with the criminal justice system. Charges? Status (pre-adjudication, in jail, probation, parole, adjourned in contemplation of dismissal)? Special considerations related to this application?)

Other agency involvement (Describe any current or past involvement with other agencies. E.g. DDSO, ARC, Child protective / preventive services, etc.)

Describe any special condition that would have a bearing on the individual's ability to live independently.

Goals: (What do you expect the individual to accomplish by virtue of his/her receiving housing and support services?)

Applicant Self-Certification on Homeless Status

In order to receive supportive housing through ETC's Shelter Plus Care programs, the Rapid Re-Housing Program, and the Evergreen Townhouse Community Program, the applicant must meet one of the following homeless criteria.

Please indicate from the choices below which best describes your current living situation:

- Person sleeping in a car
- Person sleeping in a park
- Person sleeping in an abandoned building
- Person sleeping on an bus or train station
- Person sleeping in an airport
- Person sleeping in a camping ground
- Person sleeping in a hotel/motel paid for by charitable organizations or federal/state/local government programs (Ex – DSS paying for emergency housing at local hotels/motels in area)
- Person coming from transitional housing for homeless persons (Ex – HPRP, RRH, MHAB)
- Person being evicted from a private dwelling and will lose primary residence within **14 days** **AND** have no subsequent residence identified **AND** lacks the resources or support networks needed to obtain other permanent housing.
- Person exiting an institution where (s)he resided for 90 days or less **AND** were residing in emergency shelter or place not meant for human habitation immediately before entering institution (Ex – Jail, Hospital, etc)
- Persons attempting to or fleeing domestic violence

Please circle the appropriate answer to this question:

Do you consider yourself to be an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more **OR** has had at least 4 homeless episodes in the past 3 years?

YES

NO

Self-Certification Statement

I certify that as the individual/head of the household, this information is true and complete to the best of my knowledge and will be used solely for the purposes of determining eligibility for this program and no other purposes.

Applicant's Name (please print)

Applicant's Signature

Date

Applicant Self-Certification on Homelessness/Housing History

Please list ALL of your previous living arrangements for the last year 3 years and indicate whether you lived with others or alone:

<u>From Date</u>	<u>To Date:</u>	<u>Where:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Self-Certification Statement

I certify that as the individual/head of the household, this information is true and complete to the best of my knowledge and will be used solely for the purposes of determining eligibility for this program and no other purposes.

Applicant's Name (please print)

Applicant's Signature

Date

Request for Housing Services and Information Release Authorization

Name: _____

DOB: _____

I request that I be considered for the Following Housing Program(s):

<input type="checkbox"/> Shelter Plus Care Program	<input type="checkbox"/> Shannon's House
<input type="checkbox"/> Rapid Re-Housing Program	<input type="checkbox"/> MHAB
<input type="checkbox"/> Evergreen Townhouse Community	

I am knowledgeable of what the above named program consists of and I understand that acceptance into the above program is decided by the Review Committee. I understand that this committee is composed of representatives of the Clinton County Housing and Rehab Selection Committee. I understand that the members of this committee have agreed to be bound by the highest standards defined by law (42 C.F.R. Part 2) to maintain the confidentiality of the information presented to the committee and to not discuss that information outside the scope of the committee. The committee's decision will be based on information about me from a variety of sources available to the committee.

With this understanding, I give my permission for members of the Review Committee to share information regarding me in order to determine my eligibility for the services named above. I further understand that I may withdraw this request and permission to share information (except for actions already taken) at any time without jeopardizing future application for these services. Unless my permission is withdrawn I understand that this request / authorization will remain in effect as long as I continue to receive the services covered by this committee.

Signature: _____

Date: _____

Witness: _____

Date: _____

Withdrawal of Request / Authorization

I voluntarily withdraw my request for housing and / or support services and in so doing withdraw my authorization for the Review Committee to continue to share information regarding me. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Signature: _____

Date: _____

Witness: _____

Date: _____