Maine Department of Health and Human Services
Office of Behavioral Health

Permanent Supportive Housing Program (PSHP)
Tenant-Based Rental Assistance (TBRA)

What is PSH?

Permanent Supportive Housing (PSH) is permanent housing in which rental assistance and supportive services are provided to assist households with at least one member (adult or child) with a disability in achieving housing stability.

What are the DHHS - PSHP Requirements?

To be eligible for PSHP, the head of household must be (1) homeless as defined by the US Department of Housing and Urban Development (HUD), (2) a person who has a long-term disability **and**, (3) in need of supportive services and eligible for MaineCare services.

If you have been matched to PSHP in Maine's Coordinated Entry System please complete the attached application; please note that although documents verifying household income are not required to submit this application, documentation will be required for all household members before rental assistance can be provided.

While we hope you answer all the questions, we can begin processing your application as long as you answer all of the questions that have an asterisk * next to them. Eventually you will need to answer all questions and provide documents verifying your answers. Eligibility documentation is required as stated below.

Homeless Verification:
Have a primary nighttime residence that is a public or private place not meant for human habitation; or

Be living in a publicly or privately operated shelter designated to provide temporary living arrangements, such as emergency shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs; or

Are exiting an institution where you have resided for 90 days or less and were considered homeless immediately before entering that institution (need to provide verification of prior homelessness); or

Are fleeing, or attempting to flee domestic violence, and you have no other residence and lack the resources or support networks to obtain other permanent housing.

Please see the "Documenting Homelessness" section of the application for the HUD established Order of Priority for documenting literal homelessness.

Disability Verification:
To verify your disability a Disability Verification Form must be completed by 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) or, if a qualified professional cannot complete the Disability Verification Form, then your disability can also be verified by providing one of the documents listed in the "Guide to PSHP Disability Verification" located on the OBH and Shalom House website**.**

Supportive Service Verification:
The Permanent Supportive Housing Program (PSHP) program is required to make available supportive services to program participants. The PSHP supportive services are provided through MaineCare and are intended to help participants obtain and maintain housing stability.

It must be verified that you are eligible or are currently enrolled in MaineCare (Medicaid). MaineCare provides free and low-cost health insurance to Mainers who meet certain requirements, based on household composition, income, and/or disability status. MaineCare eligibility will be determined by the criteria set forth in the MaineCare Eligibility Manual.

Where do I send my application?

In Person Dropoff: Dropbox or Front Desk – 106 Gilman Street Portland, ME 04101 **Fax**: 207-874-1077 attn: PSHP Applications
Mail: PSHP Applications - Shalom House 106 Gilman Street Portland, ME 04101 **Email**:PSHP@shalomhouseinc.org

What happens after I have submitted my application?

Once your application is received by our program, it can take up to 15 days to process. Once your application is processed you will receive a letter in the mail that reflects one of the following: a notification of award, a notification of conditional award, a notice that the application is incomplete, or a notice of denial letter with further instructions. If you do not receive a response after 15 days, please contact Shalom House.

PERMANENT SUPPORTIVE HOUSING PROGRAM APPLICATION

Please complete the entire application as fully as possible. The application will not be considered complete unless all of the questions that have an asterisk * are completed. Attach any required documents and return them with the signed application to the address shown on page 1. If you have any questions, please call (207) 874-1080.

APPLICANT INFORMATION (Head of Household)
**Indicates as required field.*

***First Name:** _____ ***Last Name:** _____

***Primary Telephone:**_____ **Secondary:**_____

Telephone:_____

***Mailing Address** (Where you receive mail): _____

***City**_____ ***State:** _____ ***Zip:** _____

What county would you like to live in? _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____

***Social Security Number:** _____ ***DOB:** _____

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

Race (check all that apply):

☐ American Indian, Alaskan Native, or Indigenous
☐ Black, African, or African-American
☐ White or Caucasian
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ Other/Multi-Racial: _____

Do you have a preferred language, other than English? (Specify): _____

An interpreter service is available upon request. Please notify the program if alternative methods are needed.

***What is the best method to get into contact with you.** (please check all that apply).

Phone: ☐ _____
Email**:** ☐ _____
Mail: ☐ _____
Other ☐ _____

Alternative Contacts or individuals you would like to add as alternative contacts for this process:

Rep. Payee: ☐ Yes ☐ No _____
Service Provider: ☐ Yes ☐ No _____
Case Manager: ☐ Yes ☐ No _____
Guardian: ☐ Yes ☐ No _____
Other: ☐ Yes ☐ No _____

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

Per HUD, Domestic Violence includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or makes him or her afraid to return to, their primary nighttime residence (including human trafficking).

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

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

*HOUSEHOLD COMPOSITION

List ALL persons who will live in the unit and complete their information. This can include unrelated people. If a caretaker or live-aide will live in the household, you will need to provide verification from a provider for the medical necessity. If approved, the aide will be counted for the household size, but will not count towards income.

Please note: You will need to fill out a Household Member Form for everyone living in the household.

Name:	Relationship to Applicant:
_____	_____
_____	_____
_____	_____
_____	_____

*HOUSEHOLD INCOME AND ASSISTANCE SOURCES:

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	$_____	☐ Employer Provided Insurance
Other (Source): _____	$_____	☐ Other: _____
TOTAL Monthly INCOME:	$_____	

*__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 – See below.*

- ☐ 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)
- ☐ Living in a place not designed for habitation
- ☐ Living in emergency shelter or hotel with emergency funds
- ☐ Transitional housing for formerly homeless
- ☐ Hotel/Motel paid for by city or state government or a charitable organization
- ☐ Victim of Domestic Violence Situation
- ☐ Other: Specify:_____

__DOCUMENTING HOMELESSNESS__

HUD has established an Order of Priority for documenting literal homelessness. This order of priority establishes guidelines for how program staff should prioritize different forms of documentation, with attempts to collect higher-priority documentation before moving on to lower- priority documentation. Reasonable efforts should be made to follow the order of priority established by HUD. The order of priority is as follows:

1. **Third Party Verification** – Intake staff should make a reasonable effort to obtain third party documentation for current literal homelessness and for all 12 months showing chronic homelessness. For months that cannot be covered by third party documentation, the effort to do so should be recorded as due diligence.
2. **Intake Worker Observation** – Where applicable, intake worker observation should take priority over self-certification of literal homelessness.
3. **Self-Certification** – For any month that the applicant must document literal homelessness because third-party verification or intake-worker observation is not available, the applicant must provide self-certification of their living situation during that month.

   Please Note: *All 12 months used to establish chronic homelessness must be covered by one of the following: third party verification, intake worker observation, or self-certification by applicant*. (*No more than 3 months of the 12 can be covered by self-certification only*)

Please submit homeless documentation with application. Applications without proper homeless verification cannot be reviewed and my be returned to the applicant.

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 that they are confirming) must complete this form.

Name: _____ DOB:_____

SECTION 1: QUALIFYING DISABILITY

In order to qualify for assistance, the individual must have a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)). Under this definition, a qualifying disability is a:

1. Physical, mental or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, brain injury or a chronic physical illness that:
   - Is expected to be long-continuing or of indefinite duration; **and**
   - Substantially impedes the person's ability to live independently; **and**
   - Could be improved by more suitable housing.
2. Developmental Disability: Defined in Section 102 of the Developmental Disability Assistance and Bill of Rights Act of 2000. Means a severe, chronic disability that:
   - Is attributable to a mental or physical impairment or combination; **and**
   - Is manifested before age 22; **and**
   - Is likely to continue indefinitely; **and**
   - Results in substantial limitations in three or more major life activities, **and**
     - Self-care
     - Receptive and expressive language
     - Learning
     - Mobility
     - Self-direction
     - Capacity for independent living
     - Economic self-sufficiency
   - Reflects need for:
     - A combination and sequence of special, interdisciplinary, or generic services; **or**
     - Individualized supports; **or**
     - Other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Does the individual have a qualifying disability as defined above? ☐ YES ☐ NO

SECTION 2: TYPE OF DISABILITY
The individual named above is an individual with (a): (Check all that apply)

☐ Mental Health Disorder
☐ HIV/AIDS
☐ Developmental Disability
☐ Chronic Alcohol Abuse
☐ Chronic Substance Abuse
☐ Physical Disability
☐ Other Disability _____

_____ _____
Name and Credentials of Provider Agency and Telephone Number

_____ _____
Signature Date

***<u>Supportive Services</u>**

If you are currently enrolled in MaineCare please provide your MaineCare ID: _____

Please review the list of services below and check services that you have or had within the past year. Please include the provider and phone number if possible.

Service	Provider	Phone
Alcohol or Substance Abuse Services		
Case Management		
Food/Food Pantry		
Housing Navigation/Counseling		
Legal Services		
Life Skills (*Peer Support, In-Home*		
Mental Health Services		
Outpatient Medical Services		
Outreach		
Non-Emergency Transportation		
Other: (Specify): _____		
Other: (Specify): _____		

Are there any services that you are not receiving already that you would be interested in finding out more information about?
☐ Yes ☐ No

_____
_____
_____

If you are currently receiving case management services, please list the agency, provider, and contact information below:

_____
_____
_____

*HOUSEHOLD MEMBER FORM

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

Please include copies of this form for every member of your household.

1. Household Member Name: _____ **2. Social Security Number:** _____

3. Relationship to HOH: _____ **4. Date of Birth:** _____

5. Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____

6. Are you Hispanic or Latino? ☐ Yes ☐ No **7. Are you a Veteran?** ☐ Yes ☐ No

8. Race (check all that apply):

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

9. Do you have a Disabling Condition? ☐ Yes ☐ No **If yes, please select all that apply.**

☐ Mental Health Disorder
☐ Alcohol Abuse
☐ Chronic Health Condition
☐ HIV/AIDS
☐ Physical Disability
☐ Substance Abuse
☐ Developmental Disability

10. Income and Other Assistance Sources: ☐ No Financial Resources

Income Sources (*SSI/SSDI, Employment, etc*) *State supplement, TANF, Child Support, etc)*	***Monthly Amount***	**Non-Cash Assist Sources** *(Food Stamps, MaineCare, Medicare,*
_____	$ _____	☐ SNAP/Food Stamps ☐ WIC ☐ SCHIP
_____	$ _____	☐ Medicare ☐ Medicaid
_____	$ _____	☐ VA Medical Services ☐ Indian Health Services
_____	$ _____	☐ Employer Provided Insurance ☐
_____	$ _____	Other:_____
_____	$ _____	☐ No Assistance Sources

11. Where are you currently residing, or where was your last residence?

_____

Length of Stay: _____ | Zip Code: _____

12. 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: _____/_____/_____

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

13a. If yes, when:
☐ Within the past three months ago
☐ From six to twelve months ago
☐ Three to six months ago
☐ More than a year ago
☐ Refused to Answer

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.

Privacy Act Statement: The information on this form is being collected on behalf of the Department of Housing and Urban Development (HUD) to help determine an applicant's eligibility. It will be used to provide the basis for managing the program covered by this form, for protecting the Government's financial interest and for verifying the accuracy of the information furnished. Penalty for false or fraudulent statements: U.S.C. Title 18, Sec 1001, provides that "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both." Applicant(s) Statement: I understand that false statements or information are punishable under federal law

_____ _____

**Applicant or Guardian Signature* **Date*

Guardian Address & Phone Number: _____

Prepared/Reviewed by: _____

Please sign name and credentials

Agency: _____ **Telephone:** _____

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 for the purposes of coordinating care and facilitating access to housing resources.

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 quickly meeting your unique needs.
- 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 status, 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 status, 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 status information may have implications. Release of HIV status 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;
- All Youth Emergency Shelters;
- Maine DHHS Youth Outreach Services;
- Any Runaway and Homeless Youth Program;
- Any other Youth program entering data for clients 17 years of age and younger.

This consent does apply to information collected for Youth Homeless Demonstration Project projects (18 plus)

Maine's HMIS Authorization to Disclose Information

☐ **YOUTH PROVIDER DISCLOSE:** *I am an individual seeking services at* a youth emergency shelter, Maine DHHS Youth Outreach Services, or a Runaway and Homeless Youth Program, *and my record is locked down. For the purposes of accessing the Maine Coordinated Entry System, I consent to having only my Client Record information (Name, Social Security Number, and Veteran Status) and my Coordinated Entry Assessment Information shared.*

☐ **DO NOT DISCLOSE (Do Not Share):** 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.

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 five (5) years.
  - 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.
- A (1) separate sub-contractor of Agency or (2) social service agency may be collecting my information on behalf of the above listed Agency to send to the above listed Agency. This sub-contractor or social service agency is bound by the same privacy rules in handling your personal information as Agency is.
- 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:_____**

If client chooses not to disclose their information, ask that they put a check mark next to the "Do Not Disclose" box and sign the document. Fax to: HMIS Team 207-624-5768. Visibility from this point forward will be removed.

Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you? Please check.

❒ Office of MaineCare Services	■ Office of Behavioral Health
❒ Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:
❒ Division of Licensing and Certification	❒ Other:

Whose information will be disclosed? Please print clearly.

Individual's Name		Date of Birth	
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check: ■ Release/Send my information to: ■ Obtain/Get my information from:

Name of Individual Antonio Giarratano / Statewide Subsidies Manager		Organization Shalom House, Inc.	
Address 106 Gilman Street	Town/City Portland	State Maine	Zip Code 04102
Telephone 207-874-1080	Email address (optional)		

What is the purpose of the disclosure?

❒ Personal request	❒ To coordinate or manage my care
❒ For a legal matter, including testimony	❒ To see whether I qualify for insurance coverage, services, or benefits
■ Other: For program eligibility	

To share the information with others by EMAIL, please initial and complete the following.

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. **INITIALHERE** _____
Please print the email address where you want your information sent:

What information should be released or obtained? Please check all that apply.

General permission: ❒ **All** health information from the office(s) checked above ❒ Claims or encounter data (information about visits to health care providers) ❒ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020") ■ Other: Program eligibility, rental assistance and supportive service information	**Special permission: Drug/Alcohol Treatment or Referral for Services** ❒ Include **all** drug/alcohol information in the release ❒ Include only the **specific** drug/alcohol records checked: ❒ Diagnosis and treatment ❒ Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒ Payment or claims information ❒ Living situation and social supports ❒ Medication, dosages or supplies ❒ Lab results ❒ Other: _____
Special permission: Mental/Behavioral Health Services ❒ Include this information in the release ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒ Include this information in the release **Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- This form permits additional releases until it expires.

Date: _____ Signature: _____

Personal Representative's authority to sign: _____