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:** _____

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

HMIS
The Data Does Matter!

MAINE HOMELESS MANAGEMENT INFORMATION SYSTEM
AUTHORIZATION FOR DISCLOSURE OF HEALTH AND/OR PERSONAL INFORMATION

For:_____ _____
(First Name) (Middle) (Last Name) (Date of Birth)

READ FIRST: _____ ("Participating Agency") participates in a federally funded Maine State Housing Authority ("MaineHousing") program for persons who are homeless. Such participation includes collecting and entering into a Maine Homeless Management Information System ("HMIS") certain personal and demographic information Participating Agency maintains for homeless persons it serves, and such information can also include health care information (such as needs assessment information used to establish your level of housing needs and services) if Participating Agency is a licensed health care provider. Information entered and maintained in the HMIS about you can then be accessed and used by MaineHousing and other participating agencies to evaluate outcomes and the effectiveness of MaineHousing's program in reducing homelessness. Authorizing Participating Agency to collect and enter into the HMIS personal and health care information about you may reduce or eliminate the need for you to be screened repeatedly by each participating agency from which you seek services (i.e., minimize the number of times you have to "tell your story"), allow you to receive services more quickly, and enhance MaineHousing's and participating agencies' ability to provide you with more effective coordinated services to meet your housing needs. If you wish to authorize Participating Agency to disclose your personal and/or health care information to MaineHousing and other participating agencies through the HMIS, please complete and sign this form. Participating agencies who are "covered entities" under HIPAA, may use and disclose your health care information only for purposes authorized by the federal HIPAA Privacy Standards and applicable Maine health care confidentiality law, pursuant to this authorization, and pursuant to each participating agency's own Notice of Privacy Practices, which is posted at each participating agency and should be offered to you by each participating agency from which you obtain services.

By signing below, I acknowledge, understand and agree that:

- ✓ My and my dependent children's (identified below) personal and health care information and records are protected by federal and state laws and regulations governing the confidentiality of client records and cannot be disclosed without my written authorization unless otherwise provided for in such laws and regulations. All agencies that participate in the Maine HMIS have an obligation to keep confidential my personal information, identifying information, records, and any health care information, they maintain about me and my dependent children as listed on this form below.
- ✓ *Unless I strike out this sentence*, I intend for this authorization to include disclosure of (i) any mental and behavioral health information maintained by any participating agency that is a licensed mental health agency, facility or program (which I have the right to review at any reasonable time before deciding to authorize its disclosure on this form); (ii)any mental and behavioral health information related to mental health services provided to me by licensed mental health professionals (i.e., psychiatrists, psychologists, clinical nurse specialists, social workers and counseling professionals) at a participating agency; and (iii) any HIV information maintained about me by any participating agency (which disclosure of HIV information could have adverse consequences, including loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful).
- ✓ *Unless I strike out any of the following*, I intend this authorization to include (i) the disclosure of records and information the disclosing agency has received from other agencies, healthcare providers or facilities, and (ii) subsequent disclosures of information that are within the scope of this authorization.

- ✓ This authorization is also intended to include disclosure of my historical record contained within the HMIS.
- ✓ I authorize the disclosures permitted by this authorization to be made through the HMIS, by fax, mail or orally, as deemed most appropriate by the parties authorized to share my information.
- ✓ None of the parties authorized to share my information under this authorization will receive any payment or other remuneration in exchange for disclosing my information, except as may be allowed by law.
- ✓ I may refuse to authorize the disclosure of some or all of the personal or health care information described on this form concerning me or any of my listed dependents below to any of the other collaborating Maine HMIS participating agencies. However, I understand that my refusal could result in improper services or other adverse consequences.
- ✓ Participating Agency will not condition services or treatment on whether I sign this authorization.
- ✓ I may revoke this authorization at any time, in writing, by notifying the Participating Agency in the manner described in Participating Agency's Notice of Privacy Practices, except to the extent that Participating Agency or other persons or entities have already acted in reliance on it. Revocation WILL NOT be retroactive.
- ✓ There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- ✓ Data derived from my information will be used by MaineHousing to report to funders, the Maine Department of Health & Human Services, and for advocacy purposes.
- ✓ All information collected on the Client Profile, Entry, Interim, and Exit Assessments, and the Shelter/Home to Stay prioritization tool will be shared with MaineHousing and other participating agencies through the HMIS to aid and assist service providers in obtaining housing and services for me and/or my household.
- ✓ I have a right to a copy of this signed authorization.

I have read the foregoing information, or it has been read to me, and I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction.

By signing below, I give permission to the Participating Agency identified above to disclose to and obtain from MaineHousing and the other Maine agencies participating in the Maine HMIS identified on Exhibit A attached, any personal information and health care information that any of these participating agencies maintain about me, or about any of my dependent children who are not authorized by law to authorize such disclosure on their own behalf. I authorize such disclosures for purposes of evaluating my housing service needs, coordinating the delivery of housing services to me, for evaluating outcomes and the effectiveness of the MaineHousing's emergency shelter homeless program in reducing or eliminating homelessness, and for the other uses and purposes described elsewhere on this form above.

This authorization will automatically expire in thirty (30) months, unless I revoke it earlier. To the extent that this authorization authorizes disclosure of any mental health information maintained by a licensed mental health agency, facility or program, this authorization will automatically expire in one (1) year with respect to the disclosure of such mental health information, unless I revoke it earlier.

_____ _____

Signature of Client, Guardian, Health Care Power of Attorney or Health Care Surrogate — Date

Provider Use:

☐ _____ did not give permission to share and exchange information with other Maine HMIS participating agencies for the purpose of evaluating services needed and to coordinate service delivery.

☐ _____ gave limited permission to share and exchange information with other Maine HMIS participating agencies for the purposes of evaluating services needed and to coordinate service delivery.

EXHIBIT A

Maine Homeless Management Information System

AUTHORIZATION FOR DISCLOSURE OF HEALTH AND/OR PERSONAL INFORMATION

PARTICIPATING AGENCIES

Aroostook Mental Health Services, Inc.

The Bangor Area Homeless Shelter

Bread of Life Ministries, Inc.

Catholic Charities Maine

City of Portland

Area IV Mental Health Services Coalition (Common Ties Mental Health Center)

Community Health and Counseling Services

Community Housing of Maine, Inc.

Employment Specialists of Maine, Inc.

H.O.M.E., Incorporated

Homeless Services of Aroostook

Kennebec Valley Mental Health Center

Knox County Homeless Coalition

Maine Department of Health and Human Services

Maine State Housing Authority

Mid-Maine Homeless Shelter, Inc.

New Beginnings, Inc.

Penobscot Community Health Center

Preble Street

Portland Housing Authority

Rumford Group Homes, Inc.

Rural Community Action Ministry

Shalom House, Inc.

Shaw House

Sweetser

Tedford Housing

York County Shelter Programs, Inc.

Washington Hancock Community Agency

Western Maine Homeless Outreach

YANA Inc.

U.S. Department of Veterans Affairs

Veterans Inc.

Volunteers of America Northern New England, Inc.

***Applicant Initials: _____**

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: _____

15. 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: _____/_____/_____

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

16a. 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

16b. 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**