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)

AROOSTOOK COUNTY

AMHC

One Edgemont Drive

Presque Isle, Maine 04769

Tel. 207-764-3319 Fax: 207-768-5377 (Attn: BRAP)

YORK AND CUMBERLAND COUNTIES (except Brunswick, Harpswell, and Freeport**)**

Shalom House, Inc.

106 Gilman Street

Portland, ME 04102

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

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

KNOX, LINCOLN, SAGADAHOC, WALDO COUNTIES (Cumberland County: Brunswick, Harpswell, and Freeport**)**

Sweetser Mental Health Services

329 Bath Road, Suite 1

Brunswick, ME 04011

Tel. 207-373-3049 or 207-373-3118 Fax: 207-373-3105

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 (1st & 2nd 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: # 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

8. 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:	$_____	

9. Please indicate priority and <u>ATTACH VERIFICATION</u> for <u>all</u> that apply:

☐ **#1** Psychiatric Discharge: BRAP Applicants who are being discharged from Riverview (RPRC) or Dorothea Dix (DDPC), or private psychiatric hospital after a 72-hour or greater admission, or who have been discharged in the past thirty (30) days from any of such institutions. Also, BRAP Applicants who are moving, or have been discharged in the past thirty (30) days, from a State funded Residential Treatment program (Mental Health PNMI) to less restrictive accommodations, to allow for appropriate discharges from the institutions mentioned above. *Attach intake and/or discharge paperwork from program.*

☐ **#2** Homeless: BRAP Applicants who are Literally Homeless, as defined by HUD, on a ranked basis according to length of homelessness, with those being homeless the longest as the top priority. *Attach verification of living situation written on agency letterhead stating location, length of stay and dates of homelessness; include title of person completing the verification. Last documented incidence must be dated within fourteen (14) days of application submission.*

☐ **#3** BRAP Applicant is being discharged within the next thirty (30) days from a correctional facility (Jail/Prison); or has been adjudicated through a Mental Health treatment court and meets Section 17 criteria and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing. *Attach verification of stay written on agency letterhead stating location, and dates of stay; include title of person completing the verification.*

Please Note: In addition to the priorities stated, BRAP may be extended to specific projects and/or populations as determined by the Department.

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 recipient may re-apply for the subsidy, as long as he or she is eligible and in good standing with the BRAP program. Applicants who owe the BRAP program back rent, damages, security deposit, etc., may be considered for readmission provided that one of the following minimum criteria have been met:

- 100% of account balance must be paid before move in or unit transfer, not to exceed thirty (30) days; or
- Establishment of a legally assigned Representative Payee within thirty (30) days and a documented payment plan not to exceed twelve (12) months.

Failure to meet at least one of the above criteria may result in program ineligibility and termination of rental assistance.

_____ **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** Tenantôs 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
Print Nameï Other Adult Member	Other Adult Member Signature	Date

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)ð 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
Clinician Signature
information listed on the previous page (6) 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:_____

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: _____

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**