



SHELTER PLUS CARE (S+C) PERMANENT HOUSING APPLICATION

GENERAL INFORMATION

1. Candidate's Name: _____
2. Candidate's Social Security #: _____
3. Sex: _____
4. Ethnicity/Race: _____
5. Referring Agency: _____
6. Case Management Advocate (CMA) Name/Title: _____
7. CMA Email: _____
8. Referring Agency Telephone#: _____
9. Referring agency's first contact with applicant? (mm/dd/yyyy): _____
10. Is Referring Agency a current Shelter Plus Care Sponsoring Agency? ___ YES ___ NO
11. List all persons **other** than candidate who will reside in the Shelter Plus Care unit:

Name	Relationship	SEX	Social Security #	Disability (if any)

12. Emergency Contact: _____

****HUD ACCEPTABLE HOMELESS VERIFICATION MUST BE ATTACHED****

13. Is candidate currently homeless? ___ YES ___ NO
14. Prior living situation one (1) week prior to submission of Shelter Plus Care Application:
 - Street or Place Not Meant for Human Habitation – **must have written certification**
 - Emergency Shelter – **must have a letter from the shelter**
 - Transitional Housing program – **must have a letter from the program stating homeless prior to admission in their program**
 - Fleeing Domestic Violence – **must self-certify**
15. Is candidate a homeless Veteran? ___ YES ___ NO
16. Estimate number of times candidate has been homeless within the past three (3) years: _____
17. At application submission, client has been homeless:
 - Less than 1 month
 - At least 1 month but less than 6 months
 - At least 6 months but less than 1 year
 - Chronically Homeless– continuously for 1 year OR has had at least (4) episodes of homelessness in the past 3 years.

HOUSING & INCOME INFORMATION

18. Housing recommendations based on CMA's assessment:
 - SRO or Efficiency
 - One Bedroom
 - Two Bedrooms

- Three Bedrooms
- Four Bedrooms
- Five Bedrooms
- Shared Unit/House (w/ other single adults)
- Group Home

Explain reason(s) for housing recommendation. (Please include candidate's living skills):

19. Does the candidate currently have income? ___ YES ___ NO

20. Check all income sources that apply to all household members:

<input type="checkbox"/> Employment	<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSI	<input type="checkbox"/> SSDI
\$	\$	\$	\$
<input type="checkbox"/> TANF	<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Other (Specify)	HOUSEHOLD TOTAL
\$	\$	\$	\$

21. Other sources of assistance:

<input type="checkbox"/> Child Support	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Other
\$	\$	\$

HEALTH INFORMATION

22. Does candidate receive Medicaid/Medicare? ___ YES ___ NO

23. Does candidate have a communicable disease: _____

If yes, explain: _____

24. List all medication(s) candidate is currently taking for any disability(s) **other than HIV/AIDS, Substance Abuse, or Mental Illness**

Diagnosis	Medication	Dosage

LEGAL INFORMATION

25. List dates of incarceration, if applicable: _____

26. Please explain any pending charges: _____

27. If candidate is currently on probation/parole, please provide reason why:

28. Provide name and telephone of probation officer, if applicable: _____

SUPPORTIVE SERVICE INFORMATION

29. What supportive services is candidate and/or family currently receiving? (check all that apply)

- Outreach
- Case Management
- Life skills (outside of case management)
- Alcohol or drug abuse services
- Mental Health services
- HIV/AIDS-related services
- Other health care services
- Education Assistance
- Employment Assistance
- Child Care
- Transportation
- Legal
- Other (specify):

30. Are all of these services being provided by your agency? ____ YES ____ NO (if no, specify)

24. Based on Case Management Advocate’s assessment at time of application submission, what services are recommended at time of application submission? (check all that apply)

- Outreach
- Case Management
- Life skills
- Alcohol or drug abuse services
- Mental Health services
- HIV/AIDS-related services
- Other health care services
- Education Assistance
- Employment Assistance
- Child Care
- Transportation
- Legal
- Financial Assistance
- Other (specify):

Comments regarding Supportive Services to individual or family:



The Community Partnership
For The Prevention
of Homelessness

Shelter Plus Care Authorization for Disclosure of Information

I, _____, hereby request that the following information: _____ be disclosed by my physician or other mental health professional, to: _____.

I further authorize _____ to release my medical, HIV/AIDS, psychiatric, substance abuse, and/or substance abuse records to The Community Partnership for the prevention of Homelessness. This information will serve as proof of my disability(s) for consideration into Shelter Plus Care Permanent Housing. I understand that these documents will be reviewed by The Community Partnership and forwarded to the appropriate Shelter Plus Care certifying agency (i.e., The Department of Health (DOH)/Addiction Prevention and Recovery Administration (APRA), The Department of Mental Health (DMH) and/or The Community Partnership (TCP) for review and certification.

Upon my successful completion of the Shelter Plus Care certification process, I understand that my information will be discussed with the Shelter Plus Care sponsoring agency identified to provide my housing and/or supportive services during my participation in the program. I also understand that for audit and statistical purposes, this information may be made available to the Department of Housing and Urban Development (HUD) and the program's grantee.

In authorizing disclosure, I understand that this information will be used solely for the purpose of The Community Partnership's Shelter Plus Care Permanent Housing Program both now and in the future, and that this authorization for disclosure is limited to information which exists as of the date of authorization.

I understand that I have the right to inspect my records.

I further understand that I have this information can not be re-disclosed without my authorization and that the law requires this notice:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (§§ 6-2001 to 6-2062). Disclosures may only be made pursuant to a valid authorization by the client or as provided in Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

This consent is subject to revocation in writing at any time.

Candidate's Name (Print)

Case Management Advocate's Name (Print)

Candidate's Signature

Case Management Advocate's Signature

Date

Date



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Shelter Plus Care Income Reporting Agreement

I _____ understand that if accepted in The Community Partnership’s Shelter Plus Care Permanent Housing Program, I will be required to report all earnings/income (i.e., employment, unemployment, SSI, SSDI, TANF, Veteran’s Benefits, Workers Compensation, etc.) that I receive during program participation to my assigned sponsoring agency within seven (7) days of my receipt of notification.

All income changes must be accompanied by written verification (i.e., 2 consecutive current pay stubs, letter from employer, award letter from federal or local agency) from which I am receiving benefits to substantiate any income adjustments to my Shelter Plus Care rental subsidy.

Once my designated Shelter Plus Care sponsoring agency receives my required documents, they will forward my information to the Shelter Plus Care Property Administrator located at The Community Partnership to implement any income adjustments. Upon receipt of my information, the Shelter Plus Care Property Administrator will provide written notification to me, my sponsoring agency and the landlord of any adjustments made to my Shelter Plus Care rental subsidy.

This process has been implemented to ensure that I receive affordable housing within the District of Columbia and that I acknowledge my income reporting responsibilities and commitment as a Shelter Plus Care participant.

Failure to report any income changes/adjustments to my income while receiving a Shelter Plus Care rent subsidy is illegal and is subject to termination from Shelter Plus Care as well as other legal actions.

Candidate’s Name (Print)

Case Management Advocate’s Name (Print)

Candidate’s Signature

Case Management Advocate’s Signature

Date

Date



The Community Partnership
For The Prevention
of Homelessness

Shelter Plus Care Supportive Services Agreement

I, _____ understand that if accepted in The Community Partnership’s Shelter Plus Care Permanent Housing Program, I will be required to develop a supportive service contract (i.e., treatment plan, service agreement, case plan, etc.) with my assigned Shelter Plus Care sponsoring agency. I also understand that periodically, it may be necessary to revise my contract to reflect current supportive service needs and to enhance my quality of life.

If my designated Shelter Plus Care sponsoring agency does not provide supportive services, I will identify an outside agency of my choice for the provision of supportive services. I understand that I am required to cooperate with both my sponsoring agency and my identified supportive service agency in the coordination of services to ensure that my supportive service needs are identified and delivered.

In the event that my designated Shelter Plus Care sponsoring agency does not provide supportive services, I agree to notify the Shelter Plus Care sponsoring agency from which I am receiving housing placement of any change(s) with my supportive service agency. Changes may consist of, but are not limited to: a change of case managers, the identification of a new supportive service agency. Upon placement into Shelter Plus Care, I will be notified by my assigned Shelter Plus Care sponsoring agency of my supportive service requirements.

Furthermore, I understand that failure to comply with the conditions of my supportive service contract and to honor the terms of this agreement may result in my termination from Shelter Plus Care.

Candidate’s Name (Print)

Case Management Advocate’s Name (Print)

Candidate’s Signature

Case Management Advocate’s Signature

Date

Date

HIV/AIDS INFORMATION

(Only include this section if the disability is applicable)

1. Indicate date (mm/yyyy) client was diagnosed with HIV: _____ AIDS: _____

2. If client is symptomatic, list symptoms:

- 2a. _____
- 2b. _____
- 2c. _____
- 2d. _____
- 2e. _____

3. List any, if any, physical limitations resulting from HIV/AIDS:

- 4a. _____
- 4b. _____
- 4c. _____
- 4d. _____
- 4e. _____

4. List all medication(s) candidate is currently taking for **HIV/AIDS only**:

Medication	Dosage

Attach supporting documentation to this page verifying the applicant's HIV or AIDS status. Supporting documentation should contain or depict CD4/T Cell count or viral lode and may include any of the following:

- lab work/test results
- medical assessment
- recent physical

I certify that the information is accurate as shown above and in the attached supporting documentation.

Candidate's Signature

Case Management Advocate

ALCOHOL/SUBSTANCE ABUSE INFORMATION
(Only include this section if the disability is applicable)

1. Specify candidate's drug(s) of choice:

- a. _____
- b. _____
- c. _____
- d. _____

2. Has candidate been enrolled in an in-patient/out-patient alcohol/substance abuse treatment facility within the past two (2) years? YES NO

3. Does candidate currently attend AA/NA meetings? YES NO

4. Length of sobriety: (most recent episode) _____

5. List all medication(s) candidate is currently taking **Alcohol/Substance Abuse only:**

Medication(s)	Dosage

Attach supporting documentation to this page verifying the applicant's substance abuse history as well as evidence of sobriety/"clean time" during the last 6 months.

Forms of supporting documentation include the following:

- hospital/detox center documentation
- assessment verifying history
- recent negative urine screenings
- written documentation from a substance abuse treatment program verifying participation
- NA/AA meeting sheets

I certify that the information is accurate as shown above and in the attached supporting documentation.

Candidate's Signature

Case Management Advocate

MENTAL HEALTH INFORMATION
(Only include this section if the disability is applicable)

1. List all mental health diagnosis(es) in DSM-IV format in order by Axis I diagnosis first. Use ICD-9 Codes:

Diagnostic Code/ICD-9 Code	DSM-IV Nomenclature

2. List all psychiatric/forensic hospitalizations within the past five (5) years and indicate the appropriate hospitalization.

Hospitalization	Location	Date

3. List all medication(s) candidate is currently taking for **Mental Illness only**:

Medication	Dosage

Attach a Psychiatric Assessment to this page verifying the applicant’s mental health history. The Psychiatric Assessment must have been conducted within no less than the past 3 months and must include the license number and hand-written signature of the Psychiatrist completing the assessment.

I certify that the information is accurate as shown above and in the attached supporting documentation.

Candidate’s Signature

Case Management Advocate

Shelter Plus Care Application Checklist

Use this checklist to ensure that all required documentation is attached and completed. Please note: Ensuring all information is submitted as required will expedite the review and certification process.

Candidate's Name

Referring Agency



REQUIRED FOR ALL APPLICANTS

- COMPLETED** SHELTER PLUS CARE APPLICATION
- SIGNED AUTHORIZATION FOR DISCLOSURE OF INFORMATION
- SIGNED INCOME REPORTING AGREEMENT
- SIGNED SUPPORTIVE SERVICES AGREEMENT
- HOMELESS VERIFICATION



REQUIRED WHERE APPLICABLE TO APPLICANT

- HIV/AIDS INFORMATION W/DOCUMENTATION
- ALCOHOL/SUBSTANCE ABUSE INFORMATION W/DOCUMENTATION
- MENTAL HEALTH INFORMATION W/RECENT PSYCHIATRIC ASSESSMENT

STAFF SUBMITTING APPLICATION: _____

DATE SUBMITTING TO THE PARTNERSHIP: _____

MAILED TO:

ATTN: Shelter Plus Care Program
The Community Partnership for the Prevention of Homelessness
801 Pennsylvania Avenue, SE, Suite 360, Washington, DC 20003

FAXED TO: 202-543-5361

ATTN: Shelter Plus Care Program

****Please note: The referring Case Management Advocate will be contacted should additional information be required to complete the certification process.*