

**METROPOLITAN HOUSING ACCESS PROGRAM  
HOUSING PROGRAM APPLICATION  
DISTRICT OF COULUMBIA**

**Housing Application Information Sheet**

Applicants may apply for District of Columbia Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) housing service by contacting Housing Counseling Services to schedule a housing application intake appointment or by completing the application with their Medical Case Manager and submitting the application to:

Housing Counseling Services, Inc.  
Metropolitan Housing Access Program (MHAP)  
2410 17<sup>th</sup> Street, N.W., Suite 100  
Washington, DC 20009  
Tel: 202.667.2681  
Fax: 202.667.0862

**A completed housing application package will consist of the following items**

- ❖ Completed District of Columbia HOPWA Housing Application
- ❖ Completed Housing Plan (identify short term and long term actions to stabilize housing)
- ❖ Verification of HIV/AIDS diagnosis of applicant
- ❖ Verification of District of Columbia residency
- ❖ Documentation of all household income (if adult household member has no income, he/she must complete and submit a *Zero Income Statement*)
- ❖ Picture ID for all adult (18 years or older) members of household
- ❖ Verification of all minor children (younger than 18) in household (Birth Certificate or Social Security card)
- ❖ Tuberculosis test results for applicant (within 12 months of application)
- ❖ If applicant is also applying for the HIV/AIDS Administration's Shelter Plus Care Program, include the following documentation:
  - Verification of homelessness (see attached "Homelessness Verification Form" for acceptable documentation)
  - Verification of severe and persistent mental impairment that limits the applicant's ability to live independently (verification must be provided by psychiatrist)
- ❖ Case manager submitting housing application must sign and complete Page 8

**Applicants applying through a community medical case manager will receive a confirmation of receipt of MHAP Housing application from HCS upon our receipt. The applicant will be informed of any additional documents required to verify eligibility for housing. Eligibility determination for HOPWA housing will not occur until all required documentation is received by HCS.**

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**Section 1: Applicant Information**

**Date:** \_\_\_\_\_ **Unique ID:** \_\_\_\_\_

**Applicant's Name:** \_\_\_\_\_  
Last Name First Name Middle

**Current Address:** \_\_\_\_\_  
Street Apt. #  
\_\_\_\_\_ City State Zip Code

**Phone Number:** \_\_\_\_\_  
Home Alternate

**Housing Program applying for (only select one):**

- \_\_\_ HOPWA Tenant Based Rental Assistance (TBRA) Program  
\_\_\_ HOPWA Shelter Plus Care Program  
\_\_\_ HOPWA Emergency/Supportive/Transitional Housing

**\*\*Note: If applying for HOPWA Shelter Plus Care, verification of homelessness and a comprehensive psychiatric assessment must be submitted with this application package.**

**EMERGENCY CONTACT (Whom should the program call in case of emergency?)**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Apt City State Zip

**Phone Number (HM):** \_\_\_\_\_ **(WK):** \_\_\_\_\_

**Is the emergency contact aware of applicant's HIV status?** \_\_\_ Yes \_\_\_ No

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**Section 2: Applicant Demographic Information**

**Gender:**      Male      Female      Transgendered

**Ethnicity:**    Latino/Hispanic                    Not Latino/Hispanic

**Race: (Check only one)**

*Single Race*

American Indian/Native American                    Asian                                    Black/African American  
 Native Hawaiian or Other Pacific Islander    White

**Or**

*Multi-Race*

American Indian or Alaska Native and White                    Black/African American and White  
 Asian and White                                    American Indian/Alaska Native & Black /African American  
 Other Multiple Race

**Language:** Is English applicant's primary language?  Yes  No

If no, what language is applicant's primary language: \_\_\_\_\_

**Veteran Status:** Is client a U.S. Veteran?  Yes  No

**Client's Acuity Level** \_\_\_\_\_ (*choose from options below*)

Level 4 = Client is homeless, in immediate danger of homelessness, or unable to live independently  
Level 3 = Client in transitional housing or unstable housing, at risk for eviction due to financial strain, or needs ongoing financial assistance to maintain current rental unit  
Level 2 = Client has adequate housing but needs occasional financial assistance to remain stable  
Level 1 = Client is not in danger of losing housing (but is rent burdened)

**Current Housing Situation:**

Renting                                    Transitional Housing Program                    Homeless (on street)  
 Live with Family/Friends            Hospital/Medical Facility                    Drug Treatment Program  
 Own    Shelter    Other \_\_\_\_\_

**Family Status (Check all that apply):**

Single Person Household    Multiple-person Household    Children under 18 in household

**Current HIV Status:**

Stage 1 (CD4 > 500)                    Stage 2 (CD4 200-499)                    Stage 3 (CD4 < 200)

**Functional Status:**

Capable of normal activities                    Problems with normal activities (needs no assistance)  
 Difficulty w/ normal activities (needs assistance)    Bedridden

**Mental Health Status:**

Currently being treated for mental illness    Previously treated for mental illness  
 Need treatment for mental illness            No history of mental illness

**Substance Abuse Status:**

Currently using illicit substance            History of illicit substance usage (but not currently using)  
 No history of illicit substance usage

# METROPOLITAN HOUSING ACCESS PROGRAM HOUSING PROGRAM APPLICATION DISTRICT OF COLUMBIA

## Section 3: Household Information

### HOUSEHOLD COMPOSITION & INCOME INFORMATION

Please complete this section for applicant and any other persons currently living in applicant's household.

NAME	RELATION TO APPLICANT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	HIV POSITIVE (Y or N)	ANNUAL GROSS INCOME	SOURCE OF INCOME
1.	Applicant					
2.						
3.						
4.						
5.						
6.						
Please submit additional form to list other household members.					TOTAL HOUSEHOLD ANNUAL INCOME	

**Is the applicant also head of household?**     Yes     No

**If no, who is head of household:** \_\_\_\_\_

**Identify all housing programs that household has applied to previously:**

HOPWA Housing     Housing Choice Voucher Program (Section 8)     Public Housing

Shelter Plus Care Housing     Project Based Housing     Senior Housing

Other: \_\_\_\_\_

**Results/Outcome of housing program application(s):**

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**Has a member of the household ever been terminated from a federally subsidized housing program?  Y  N** If yes, please identify housing program and describe the circumstance surrounding the termination.

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**Section 4: Housing and Support Services Needs Assessments**

**Provide responses to the questions below. If the applicant's response is "Yes" to a question, please provide a brief explanation in the "Comments" column.**

Needs	Response	Comments
Is the applicant's household currently in an unstable housing situation or currently homeless?	___ Yes ___ No	
Does the applicant or a household member have special housing needs (ex. wheelchair accessible, nurse/home health aide, bedridden, nursing facility)?	___ Yes ___ No	
Does the applicant or a household member have difficulty performing activities of daily living?	___ Yes ___ No	
Does the applicant have any current mental health diagnosis/ concerns or is the applicant currently receiving mental health treatment?	___ Yes ___ No (If yes, please identify diagnosis and provide contact information for treatment provider.)	
Is the applicant or a household member currently using (or recently used) an illegal/illicit drug?	___ Yes ___ No (If yes, please provide date of last use: _____)	
Has the applicant or a household member been convicted of criminal charge?	___ Yes ___ No	
Does the applicant currently receive primary medical/ community case management services?	___ Yes ___ No	Name of case management agency _____ Name of case manager _____ Telephone number _____

**METROPOLITAN HOUSING ACCESS PROGRAM  
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Individual Housing Plan (IHP)**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Unique ID:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_

Identified Areas of Need	Goal (s)	Interactions/Activities/ Actions	Review/Due Date	Persons responsible for action	Outcome/Linkages

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Case Manager Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# HOUSING COUNSELING SERVICES

## Section 5: Disclosures and Authorizations

### Disclosure Statement

To the best of my knowledge and belief, I certify that the foregoing information is true, complete and accurate. I understand that if I have provided any false information, this may result in the denial of my application for the housing services for which I am applying. I understand that Housing Counseling Services, Inc. (HCS) may need to contact individuals and/or agencies (including landlords, employers, government agencies, and medical/support service providers) to acquire information and verify eligibility for its programs and to maintain contact with me. My signature serves as my consent for HCS to contact individuals and/or service provider(s) necessary to document my need. Also, as a participant in a program funded by the local and federal government, I understand that annual audits will be conducted to verify HCS' compliance with local and federal regulations. I authorize HCS to allow the review of my personal program file, including all verifications and documentation, by the HCS Organizational Auditor or Funding Agency Compliance Auditor/Monitor. All Auditors/Monitors are prohibited from disclosing any personal client information to any source. This authorization will remain in effect as long as an Organizational Auditor or Compliance Auditor/Monitor determines that the review of client files is necessary to complete federally mandated audits, reviews and report(s). This form has been read by or to me prior to my signing it. My consent is subject to revocation in writing by me at any time and, if not earlier revoked, it shall terminate on exit from the Housing Program application process or five (5) years from the date of my signing this document, whichever comes first.

Client Signature:

Witness:

Date:

Date:

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**Authorization of Representation/Release of Information**

The applicant authorizes that \_\_\_\_\_ (name of case manager) is permitted to represent the applicant in the process of applying to this housing program and has permission to release information and receive information related to all matters concerning the applicant in the process. In addition, the applicant authorizes Housing Counseling Services (HCS) to release information to housing and service providers operating within the HOPWA Housing system. This release may be revoked at any time verbally or in writing.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Application Completed By**

Application completed by  
(Case manager name): \_\_\_\_\_

Case Manager Signature: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

**By signing this application, the case manager confirms that this housing application was completed at the request of the applicant and in the presence of the applicant.**