

**METROPOLITAN HOUSING ACCESS PROGRAM
HOUSING PROGRAM APPLICATION
CHARLES COUNTY MARYLAND**

Housing Application Information Sheet

Applicants may apply for Charles County Maryland Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) housing services by completing this application with your primary case manager and submitting a completed application package to:

Housing Counseling Services, Inc.
Metropolitan Housing Access Program (MHAP)
2410 17th 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 Charles County Maryland HOPWA Housing Application
- ❖ Verification of HIV/AIDS diagnosis of applicant (lab report or physician statement)
- ❖ Verification of Charles County Maryland residency
- ❖ Documentation of all household income within the last 30 days (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)
- ❖ Completed Individual Housing Plan form
- ❖ Case manager submitting housing application must sign Page 8

Applicants applying through a community case manager will receive a confirmation of receipt of MHAP Housing application from HCS upon our receipt. Failure to submit all required eligibility documentation with the application will result in the denial of the application. HCS may request additional documentation to verify circumstances presented in the application. HCS may also request that the applicant meet with HCS staff person if it is determined that there are concerns regarding housing stability.

***If you are not receiving case management services you may contact HCS for a referral for case management services.**

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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

Ward: _____

Phone Number: _____
Home Alternate

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

Ethnicity: Hispanic Not Hispanic

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

Veteran Status: Is applicant 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 _____

Homelessness Status:

Continuously homeless for 1 year or more Four episodes of homelessness within the past 3 years
 Not applicable

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)

Date of Last Contact with Health Care Provider: _____

Do you currently have medical insurance? Yes No

Employment Training:

Have you participated in an employment training program within the last 12 months Yes No

If yes, did the employment training result in employment? Yes No

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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)	MONTHLY GROSS INCOME	ANNUAL GROSS INCOME	SOURCES OF INCOME (Work, SSDI, TANF, etc.)
1.	Applicant						
2.							
3.							
4.							
5.							
6.							
Please submit additional form to list other household members.					Total	Total	

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):

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): _____

Organization: _____

Address: _____

Phone Number: _____

Case Manager Signature: _____

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.