Don't staple the pages of this application together!

1. Some providers *scan* the application, and if you staple, that means removing staples from 1000 applications every week or month.
2. If you include a letter, don't staple that either: providers need to quickly get to your waitlist data and your cover page just gets in the way.

Use #10 double-window envelopes. Fold on the line, and addresses will fit in the windows.

Dear

I am applying to the following waitlist, which I believe is open: *App Generated:*

Housing Authority or Management Office Only

Is this waitlist closed? Any other questions or concerns? *Fill in the appropriate circle(s) below and fax this page to HousingWorks at the number below – and we will correct the problem. Hundreds of thousands of applicants check our free website to see what lists are open! Keeping us updated will save you many phone calls, reduces frivolous applications - and takes only 10 minutes a year.*

○ **This particular waitlist is closed: The only open waitlists we have at present are:**

_____

○ **This is not the correct application. The correct application is available by/from:**

_____

○ **Any other info you wish to tell HousingWorks?**

_____

Your position or title at this housing program: _____

Your signature: _____

HousingWorks Fax: **617-536-8516**

HOUSINGWORKS
For Everyone

	Head of Household's FIRST Name
○	
	Head of Household's MIDDLE Name
○	
	Head of Household's LAST Name
○	

	HoH's SOCIAL SECURITY NUMBER		GENDER		HoH's DATE OF BIRTH
○		○		○	

	ETHNICITY Also provide your race at right!	RACE:	Asian , Black, White, Native American, Pacific Islander, Multi-racial Do **NOT** write Spanish, Hispanic, Latino here – and do **NOT** write your country!
○		○	

○	YOUR MOTHER'S MAIDEN NAME

	YOUR HOME TELEPHONE		SECOND TELEPHONE
○			
	YOUR EMAIL ADDRESS		
○			

CURRENT ADDRESS OR LONG-TERM CONTACT ADDRESS

	This is:
○	
○	

	SECOND CONTACT ADDRESS
	This is:
○	
○	

	TOTAL HOUSEHOLD SIZE						# BEDROOMS			How much money does your family receive in a year?			
○		**#** Adults		**#** Children		Total #	○		○		**.0**	**0**	

	INCOME SOURCES
○	

	MOBILE RENTAL ASSISTANCE, if any
○	

	REQUESTED ACCOMMODATIONS
○	

	SPECIAL CIRCUMSTANCES THAT SOME PROGRAMS MAY USE TO ASSIGN PRIORITY OR PREFERENCE
○	

HOPE HOUSE INTAKE FORM

Demographics

Name_____ DOB_____

Gender_____ Race_____Ethnicity_____

Address_____

Tel. #: _____ Primary Language: _____

Soc Sec. #: _____ Occupation_____

Country of Origin_____ Immigration Status: _____

Emergency Contact Name & #: _____

Guardianship Needed/or in Place: Y ☐ N ☐ Needed ☐

Power of Attorney Needed/or In Place Y ☐ N ☐ Needed ☐

D.N.R. Needed/or In Place Y ☐ N ☐ Needed ☐

Health Care Proxy Needed/or in Place Y ☐ N ☐ Needed ☐

Medical History and Assessment:

Risk factors for HIV Infection: _____

Date of HIV Test: _____ Date of Last T.B. Test: _____

Date of last Chest X-Ray: _____ Most Recent Viral Load: _____

Most Recent CD4 Count: _____ Genotype/Phenotype PCR: _____

☐ HIV+ Asymptomatic ☐ HIV+ Symptomatic ☐ AIDS Diagnosis

Opportunistic Infections: _____

Medical History:

Other Health Care Providers (dentists, chiropractors, acupuncturists, etc.):

Previous Hospitalizations: _____

_____

Person designated to act on your behalf in an emergency (named in health care proxy or guardian):

_____Tel # _____

Medications:

Allergies to food or medications (please describe what happened): _____

_____

List your current Medications with their dosages, and times: _____

_____

_____

Can this client self medicate? _____Yes _____No

Is nursing teaching around self-medication required? _____Yes _____No

Using the table below, please list any past HIV related illnesses/symptoms, as well as related medications and treatments.

Infection/Symptoms	Past?	Present?	Treatment	Discharge Date
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Clinical Trials:

Type of clinical trial or expanded access medications: _____

_____

Locations of trail or expanded access medications: _____

_____

Frequency of visits: _____

Who is monitoring the trial or expanded access medications? _____

_____

Nutritional Needs Assessment:

Oral_____ Enteral_____ Parenteral _____

Who will monitor and maintain the items other than oral (name of home health agency required)?

_____

Physical Examination:

Speech_____

Vision_____

Hearing_____

Motor_____

Cardiac_____

Respitory_____

Neurological_____

ADLs and IADLs Assessment:

_____Medication Mgmt	_____Diet/Nutrition	_____GYN Planning
_____Bathing	_____Dressing/Grooming	_____Eating/Feeding
_____Ambulating	_____Toileting	_____Transferring
_____Housework	_____Laundry	_____Meal Preparation
_____Getting Around Outside	_____Medication Mgmt	_____Shopping
_____Money Mgmt	_____Transportation	

Rehabilitation Therapy:

_____OT _____PT _____Speech
Functional Status _____ *Maintenance*_____ *Frequency of therapy* _____

Special Treatments:

_____

_____

_____

(*Please note frequency, and person performing treatments*)

Medical Equipment:

Assist Devices

_____Cane _____crutches _____wheelchair _____walker _____bath bar
_____commode _____bedpan _____urinal _____bath set
_____hand held shower _____Hoyer lift _____hospital bed

Disposable supplies

_____diapers _____dressing supplies ____incontinent pads

Infusion or tube feeding _____
Who will monitor and administer: _____

Reparatory equipment: _____

Medical Follow-up:

Name of MD and frequency of visits:

_____

Mental Status: (*Please check one in each section*)

Memory:	____ normal	____ short term deficit	____ long term deficit
Insight:	____ good	____ fair	____ absent
Judgment:	____ good	____ fair	____ poor
Thought Process:	____ normal	____ fragmented	____ tangential
	____loose	____paranoid	____delusional
	____hallucinations:	***if yes*** ____*audio*	____*visual*
Mood:	____relaxed	____fearful	____anxious
	____sad	____hostile	____depressed

Affect: ____appropriate ____inappropriate

Ideation: ____suicidal ____homicidal

General appearance:_____

_____

Other comments: _____

_____

Any history of psychiatric (*mental health*) problems in your family? _____

_____

Please explain in detail: _____

_____

_____

Mental Health/ Psychosocial History:

Have you had any prior mental health counseling or treatment _____Y _____N

Therapist/Agency	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric/mental Health Treatment (*inpatient and outpatient*)

Problem	Dates	Where Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current and past Psychiatric Medications: _____

_____

Date of last AIMS testing:_____ _____Not applicable _____Not previously done

Mental Health Diagnosis: Axis I _____

Axis II_____

Axis III_____

Axis IV_____

GAF:_____

_____

Substance Abuse:

Is there a history of substance abuse: Yes: _____ No: _____

Age of first use: _____

When did you usually use drugs or alcohol: _____

What are the triggers for you in your life: _____

Do many of your friends have substance abuse problems: _____

_____

How did you get the substances: _____

_____

What was your source of money for these substances: _____

How much did you spend per week for these substances: _____

_____

Primary substance of choice: _____

Other illicit substances that you have used: _____

_____

Date of last usage: _____

Usual route of transmission of the substance: _____

Have you ever had a problem with prescription medications: Yes: _____ No: _____

If yes please explain: _____

Have you ever-used drugs intravenously: Yes: _____ No: _____

If yes please explain: _____

_____

Have you ever had a drug or alcohol overdose: _____

_____

If yes was this overdose intentional: _____

_____

How long has it been since you have been drug free: _____

_____

Please list family members who have a history of alcohol or drug problems: _____

_____

Substance Abuse Treatment History:

1.) Treatment Agency:_____

Address: _____

Treatment Modality (in-patient, out patient, detox): _____

Counselor: _____

Treatment dates and length of treatment: _____

Reason for discharge: _____

2.) Treatment Agency:_____

Address: _____

Treatment Modality (in-patient, out patient, detox): _____

Counselor: _____

Treatment dates and length of treatment: _____

Treatment Needs: _____

_____

Alternative Treatments:

Holistic: _____

Acupuncture: _____

Massage: _____

Other: _____

Psychological and Substance Assessment:

Assessed as needing:

Individual or family counseling: _____

(if yes, was referral made) _____Y _____N _____Refused _____Needed

(*to whom was the referral made*): _____

_____

Psychiatric care: _____

(if yes, was referral made) _____Y _____N _____Refused _____Needed

(to whom was the referral made): _____

_____

Support Groups: _____

(if yes, was referral made) _____Y _____N _____Refused _____Needed

(*to whom was the referral made*):_____

_____

Spiritual Needs:

Religious preference:_____

Participation and Frequency:_____

How important is religion to the resident_____

Family and Support Network:

Is the client married _____YES _____N _____Divorced

Is the client a parent _____YES _____N

Children: (*First and last names and who has custody of them)*

_____

_____

_____

Is Family aware of your diagnosis? _____ YES _____ No

Comments: _____

_____

Other involvement from Community Agencies: _____ Yes _____ No

If Yes, Agency: _____

Contact & phone number: _____

Nature of Involvement: _____

Residential History:

Situation 1: _____
(ex: had a lease/living with family/friends)

Address: _____

Landlords Tel#: _____Dates of residency: _____ to PRESENT

Reason for leaving: _____

Situation 2: _____
(ex: had a lease/living with family/friends)

Address: _____

Landlord's Tel # _____ Dates of residency: _____

Reason for leaving: _____

Situation 3: _____
(ex: had a lease/living with family/friends)

Address: _____

Landlord's Tel # _____Dates of residency: _____

Reason for leaving: _____

Housing Client Information Form

Mass. DPH HIV / AIDS Bureau

☐ New Client
☐ Update

Submit HCI Form

Date Completed (month / day / year)

Client code: (1st 3 letters of mother's first name | Birth (MM-DD-YY) | Last 4 digits of SSN)

Client code of head of household (if different from above):

Case number: (from Case Info Form)

Household : (assigned by DPH)

Sex: (M, F, T (Transgender), or U (Unknown))

Has Primary Care Provider? (Y or N)

Case Manager: (3 initials)

Most recent residence: (city | ZIP | State / Country if not MA)

Please enter ZIP code of most recent residence before application if it differs from household data entered previously. Enter state if ZIP is unknown. Use 99999 = homeless 1 year or more.

Hispanic /Latino? (Y or N)

Race / Ethnicity: (Check all that apply.) =

- ☐ 01 = White
- ☐ 02 = Black or African-American
- ☐ 04 = Asian / Asian American
- ☐ 05 = Native American / Alaskan Native
- ☐ 06 = Haitian
- ☐ 07 = Brazilian
- ☐ 08 = Cape Verdean
- ☐ 09 = Portuguese
- ☐ 10 = Native Hawaiian or other Pacific Islander
- ☐ 98 = Other (specify above)
- ☐ 99 = Undetermined / Unknown

Primary Language: (fill in code or write language for "other" language (09))

English as a 2nd Language?: (Y or N)

- 01 = English
- 02 = Spanish
- 03 = Haitian Creole
- 04 = French
- 05 = Portuguese
- 06 = Crioulo (Cape Verdean)
- 07 = S. E. Asian Languages
- 08 = American Sign Language
- 09 = Other (specify above)

=

Transmission Risk Factors: (Check all that apply.)

- ☐ 01 = Men who have sex with men
- ☐ 02 = Women who have sex with women
- ☐ 03 = Heterosexual contact
- ☐ 04 = Injection drug use
- ☐ 05 = Perinatal transmission
- ☐ 06 = Bisexual injection drug user
- ☐ 07 = Transfusion / blood products
- ☐ 08 = Occupational exposure
- ☐ 98 = Other (specify above)
- ☐ 99 = Undetermined / Unknown

Diagnostic Information: **Dx date:** (month / year)

- * 01 = HIV+ not AIDS
- * 02 = HIV+ AIDS status unknown
- * 03 = AIDS
- 04 = HIV negative (affected)
- 99 = Unknown / Unsure

* **HIV verification is required**

Special needs: (Check all that apply.) =

- ☐ 1= Mental illness
- ☐ 2 = Alcohol abuse
- ☐ 3 = Drug abuse
- ☐ 4 = AIDS or related illness
- ☐ 5 = Developmental disabilit
- ☐ 6 = Physical disability
- ☐ 7 = Domestic violence
- ☐ 98 = Other (specify below)

Insurance?:

- 1= Not insured
- 2 = Self-insured
- 3 = Insured thru employer
- 4 = Medicaid/free care/Medicare
- 5 = Military/VA
- 6 = Indian Health Service

Veteran?: (Y or N)

Previous participant in this housing program?: (Y or N)

ISP date: (month / day / year)

Current monthly income:

$	SSI	$	Child support	$	Medicaid
$	SSDI	$	Veteran's benefits	$	Food stamps
$	Social Security	$	Employment income	$	Other
$	General Public Assistance	$	Unemployment benefit		
$	TANF	$	Medicare		

Check if no financial resources:

Housing Waiting List Form

Mass. DPH HIV / AIDS Bureau

Please submit this form as soon as presumptive eligibility is established.

Date Completed (month / day / year)

☐ **New Case**
☐ **Update**

Submit HWL Form

Agency:

Program:

Case number:

DPH Household ID:

(enter only if known from previous admission)

Client code of head of household:

1st 3 letters of mother's first name | Birth (MM-DD-YY) | Last 4 digits of SSN

Household information

Date referral was received: (month / day / year)

Number in household at time of referral :

Most recent residence: city | ZIP | State / Country if not MA

Referral source:

1 = Self
2 = Street outreach
3 = Emergency or transitional shelter
4 = Psychiatric hospital
5 = Other hospital or medical staff
6 = Mental health outpatient clinic
7 = Housing search counselor
8 = Alcohol or other drug program
9 = Other social service staff
10 = Police
11 = PHA waiting list
12 = Church staff
98 = Other-please specify:
99 = Unknown

Current living situation:

* 1 = Street
* 2 = Emergency shelter
3 = Transitional housing
4 = Psychiatric facility
5 = Substance abuse trtmt
6 = Hospital
7 = Jail / prison
8 = Domestic violence situation
9 = Living w/ friends/relatives
10 = Rental housing
11 = Other subsidized housing
* 12 = Not fit for human habitation
13 = Participant-owned housing
98 = Other

* = ***McKinney criteria***

Total monthly household income at time of referral: ($) $0

Check if no financial resources: ☐

Presumptive Eligibility Information

Date on which found eligible: (month / day / year)

Date off eligibility list: (month / day / year)

Reason off list :

1 = Accepted into program
2 = Found ineligible before intake
3 = Withdrew application
4 = Died
99 = Unknown/lost to followup

Housing search information

Fill out this section ONLY if client is applying for scattered site housing

Date accepted: (month / day / year)

Date subsidy received: (month / day / year)

Date leased up: (month / day / year)

Reason not housed :

1 = Looking for housing
2 = Subsidy expired
3 = Withdrew application
4 = Terminated from program
5 = Died / lost to followup
6 = Medical
98 = Other
99 = Unknown

Housing Program Entrance/Exit Form

Mass. DPH HIV / AIDS Bureau

month / day / year
Date Completed

☐ **Entering client**
☐ **Exiting client**

Submit HPEE Form

Client Code: [ ][ ][ ] [ ] [ ][ ][ ][ ]
1st 3 letters of mother's first name | Birth (MM-DD-YY) | Last 4 digits of SSN

Case number: (from waiting list form) [ ]

When a client is placed...

Client placement information

Date housed: [ ] month / day / year

Site Number: [ ] (Use ZIP code for scattered site placements)

Apt. or unit number: [ ]

Unit size: [ ]
0 = Studio 1 = 1 BR 3 = 3 BR 5 = 5+ BR
S = SRO 2 = 2 BR 4 = 4 BR

Program Name: [ ]

When a client leaves...

Client exit information

Exit date: [ ] month / day / year

Primary exit reason [ ]

01 = Voluntary departure
02 = Non-payment of rent
03 = Non-compliance with prog reqs
04 = Criminal activity/destruction of property/violence
05 = Death
98 = Other-please specify: _____
99 = Unknown/lost to followup

Eviction?
Check all that apply
☐ Not Evicted
☐ Resident left after eviction proceedings initiated.
☐ Eviction proceedings completed.

Exit destination [ ]

Permanent	1 = Rental house or apartment (no subsidy) 2 = Public housing 3 = Section 8 4 = HOME subsidized house or apartment 5 = Other subsidized house or apartment 6 = Home ownership 7 = Moved in with family or friends
Transitional	8 = Transitional housing for homeless person 9 = Moved in with family or friends
Insitutional	10 = Psychiatric hospital 11 = Inpatient alcohol or drug treatment facility 12 = Jail/prison
Emergency	13 = Emergency shelter
Other	14 = Other supportive housing 15 = Places not meant for human habitation 98 = Other-please specify:_____
Unknown	99 = Unknown/lost to followup

Monthly income at exit from program:

$	SSI	$	Child support	$	Medicaid	Total Income =	
$	SSDI	$	Veteran's benefits	$	Food stamps	$0	
$	Social Security	$	Employment income	$	Other		
$	General Public Assistance	$	Unemployment benefit				
$	TANF	$	Medicare				

Check if no financial resources: ☐