

Mail this application to:

The name of the waitlist I'm applying for is: _____

Some waitlists are closed: Before sending this application, check <http://www.housingworks.net/> to see what is open

You **must** answer every question on this application: respond to questions that are not applicable by writing "N/A".
Incomplete applications may be returned or discarded.

Name of HoH: _____

Long-Term Mailing Address _____

City/State/Zip: _____
(this address should ideally work for the next 3-5 years):

Phone(s): _____ - _____ - _____ _____ - _____ - _____

Email: _____

The **SSN** for the head of household is: _____

Does the HoH have a **Social Security Number** (SSN)? ☐ Yes ☐ No *If "Yes" you must provide it above).*

What is your **date of birth**? _____ What is your **gender**? _____

Race (white, black, asian, etc)? _____

What was your **mother's last name** when she was born? *Protects your privacy*) _____

How many people will be living in the unit? _____ people. What **unit size** are you seeking? _____ BR

Describe your **Income Sources** (Job, Food Stamps, SSI, TAFDC, etc.) _____

What is your family's **ANNUAL** income? \$ _____ (do NOT write an hourly, weekly, or monthly amount!)

☐ YES ☐ NO Do you have a **rental voucher** or **some other form of regular rental assistance**?

Specify: ☐ Section 8 ☐ MRVP ☐ AHVP ☐ Homebase ☐ _____

☐ YES ☐ NO Do you need a **wheelchair accessible unit** (or a "no-steps" unit)?

☐ YES ☐ NO Do you need **reasonable accommodations** due to a disability, either during the application period or tenancy? _____

☐ YES ☐ NO Are you or any member of your household subject to a lifetime registration requirement under a **State Sex Offender Registration** program?

☐ YES ☐ NO **Priority/Preference Status:** If there is a section in this application that asks about priorities and preferences, did you claim any?

Office Only: Date/Time Stamp

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING IN MA

(Revised June, 2001)

COVER PAGE

CHECK LIST:

This application requires the following to be complete. Applicant should retain a copy.

<i>Complete</i>	<i>Forthcoming</i>	
-----------------	--------------------	--

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. UNIVERSAL PRELIMINARY APPLICATION – 4 pages. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. FIVE YEAR HOUSING HISTORY form |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. MEDICAL CERTIFICATION form |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. CERTIFICATE OF HOMELESSNESS (if required) |

Presumptive Eligibility Information (For Housing Providers use Only)

Date on which
found eligible: M____D____Y____

Reason/s off list: ☐

Date removed
From waitlist: M____D____Y____

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

Additional comments:

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING IN MA

(Revised June, 2001)

Name of the HIV HOUSING PROVIDER to which applicant is applying: _____

Date mailed: ____/____/____ Referring Person: _____

Agency: _____ Phone: _____

Client code of head
of household:

<div style="display: flex; justify-content: space-around;"> ——— </div>	<div style="display: flex; justify-content: space-around;"> ——-——-—— </div>	<div style="display: flex; justify-content: space-around;"> ———— </div>
1 st 3 letter of mother's first name	Birth (MM-DD-YY)	Last 4 digits of SSN

Applicant: _____ DOB: _____

Primary Language: _____ Social Security #: _____

Phone # where applicant accepts calls (if any): _____

Pager: _____

Cell Phone: _____

Address: _____ City/Town: _____ ZIP: _____

Place to send mail (if different): _____

City/Town: _____ ZIP: _____

Gender: _____

Race: Hispanic/Latino____Caucasian____African American____Haitian____Asian____Native American____

Other _____

Existing Case Managers (other than referring person) assisting with HIV-related issues (*optional*):

Name/Agency: _____ Phone: _____

Name/Agency: _____ Phone: _____

B.) HOUSEHOLD COMPOSITION/ INCOME:

Most HIV housing programs require that residents meet low income requirements set by the U.S. Department of Housing and Urban Development. List all persons in the planned household with any form of income including live-in boyfriends/ girlfriends. List children who are certain to live with applicant from move-in date. (Continue in section K)

<i>Names of individuals who will live with the applicant</i>	<i>Relationship to applicant</i>	<i>Age</i>	<i>Source(S) of income * (Wages, SSI, AFDC, etc.)</i>	<i>Monthly Income*</i>	<i>Annual</i>
Applicant	self				
Total Household Income:					

* Leave blank for official Personal Care Attendant for whom medical documentation can be supplied evidencing this role.

C.) MEDICAL ELIGIBILITY:

Please have applicant's physician complete attached MEDICAL CERTIFICATION form and submit with this application to verify positive HIV status or diagnosis of AIDS for applicant and/or household members. (see page 6)

Note to housing managers: HUD has deemed this medical eligibility form as an acceptable form of documentation of HIV status. However, they do suggest that once an applicant has been accepted into your program, a letter from their medical provider on stationary should be placed into the resident's file.

D.) HOUSING STATUS:

Please check the box below that best describes the applicant's housing situation for which supporting documentation can be supplied. Check only one box and be certain documentation from a third party on letterhead stationary can be produced at a later date to verify this status. Some HIV Housing Providers will have precise requirements as to the source and content of such supporting documentation.

<input type="checkbox"/>	Living in a shelter.
<input type="checkbox"/>	Living on the street (having no fixed, regular, nighttime residence).
<input type="checkbox"/>	Living in Department of Transitional Assistance Program.
<input type="checkbox"/>	Living in a transitional program (i.e. provides services on site designed to prepare the individual to move into more independent permanent housing) and homeless immediately prior.
<input type="checkbox"/>	Living in and receiving care from an institution not designed for long term residence (e.g. hospital, rehabilitation facility etc.)

<input type="checkbox"/>	Doubled up (living temporarily with friends or relatives)
<input type="checkbox"/>	In imminent danger of losing housing through no fault* of own and has received "summary process summons" from the court to proceed with an eviction (applicant need not have actually been to housing court).
<input type="checkbox"/>	Renting an apartment using a transitional subsidy such as AHVP or DMH.
<input type="checkbox"/>	Renting an apartment using a 2-year HOPWA certificate or a 2 year TBRA HOME certificate and was homeless immediately just prior to using 2 year subsidy.
<input type="checkbox"/>	Living in substandard housing (i.e. living in a unit that endangers the health, safety, or well being of the household due to being dilapidated, or due to inadequate source of heat or inadequate indoor plumbing (including toilet, and bathing facilities, or lack of electricity..
<input type="checkbox"/>	Rent burdened - paying between 50% or more of gross income toward rent and utility costs for at least 90 days (based on average monthly utility payment, excluding phone, over 12 months).
<input type="checkbox"/>	Rent burdened - paying 75% or more ...
<input type="checkbox"/>	Other (briefly describe):

E.) CERTIFICATE OF HOMELESSNESS:

Some HIV housing programs require that applicants submit an official CERTIFICATE OF HOMELESSNESS form to be in compliance with requirements of their funding sources. Consult the [HIV/AIDS Housing Program Directory of Supportive Housing Programs in Massachusetts](#) published by the AIDS Housing Corporation in Boston to learn which programs require this standard of homelessness or contact the HIV housing provider directly.

F.) HOUSING HISTORY:

FIVE YEAR HOUSING HISTORY form. Provide as much detail as possible.

Has the applicant ever lived in subsidized housing? No ☐ Yes ☐ If yes, where? _____

When (from – to): _____ In whose name was the apartment? _____

G.) J.R.I. APPLICANTS ONLY:

Applicants for JRI rental subsidies will automatically be placed on the wait list for the region where they live now. Applicants may choose an additional region outside of current residence (although they will not be prioritized for that list). Indicate chosen secondary region by checking below:

___ Greater Boston ___ Metro-West Boston ___ Northern Essex N. Middlesex County ___ Plymouth & Bristol County

___ Cape and Islands ___ Worcester County ___ Hamden and Hampshire County ___ Berkshire County

___ Franklin County

The applicant certifies that he/she qualifies as a member of the special target population for the HIV housing program to which this application is being submitted as those criteria are outlined in the [HIV/AIDS Housing Program Directory of Supportive Housing Programs in Massachusetts](#) published by the AIDS Housing Corporation in Boston. The applicant can supply supporting documentation upon request to demonstrate such eligibility.

Date: _____

Date: _____

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

MEDICAL CERTIFICATION FORM

Instructions to applicant: You should fill out Sections A and B and have your physician complete Section C and send to the HIV housing providers to which you are applying.

Section A. Request for Physicians Certification of HIV Status

Dear Medical Provider,

Your patient, _____, is applying for subsidized housing for persons living with HIV/AIDS in Massachusetts. These programs may only consider persons with a diagnosis of AIDS or who are HIV+. By signing in Section B below, the individual named authorizes you to release to us the information requested on this page.

Section B. Authorization for Release of Information

I, _____, an applicant for subsidized housing for persons with HIV/AIDS in Massachusetts hereby authorize _____, my health care provider, to release the information requested on this form to the program staff of the entities listed above:

Applicant/Date

Witness/Date

Section C. Physician's Certification

I, _____ (please print name), provide primary medical care for _____. For the purpose of his/her application for housing for persons with HIV/AIDS, I hereby certify that he/she:

- _____ has a diagnosis of AIDS
 _____ does not have an AIDS diagnosis but is HIV symptomatic or has (any) conditions arising from the virus.
 _____ is disabled due to HIV
 _____ none of the above

Medical Provider Signature

Date

Medical Provider Name Printed

Phone Number

Clinic Name and Address

FIVE YEAR HOUSING HISTORY

(Make multiple copies of this page as needed)

Please list the following information about where the applicant has lived for the past five years. Please note: A lack of rental history does not necessarily disqualify the applicant. Substitute a contact person when no landlord was involved (e.g. shelter social worker, transitional program case manager etc.)

Applicant's current address: _____ Lived here from _____ to present.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name:_____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name:_____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name:_____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name:_____Phone:_____

May we call this person for a reference? Yes___No___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___rented apartment___doubled up___transitional program___shelter___other:_____

Landlord/other contact name:_____Phone:_____

May we call this person for a reference? Yes___No___

(Use additional page if necessary)

Certification of Homelessness

To be eligible for **Shelter Plus Care** and/or **Supported Housing Programs**, an applicant must be homeless, as defined by HUD (see Massachusetts HIV/AIDS Housing Program Directory to determine funding source). Homeless is defined as living in a shelter or on the streets. An applicant who is residing in transitional housing for less than 2 years is also eligible as long as he or she was homeless according to the above definition immediately prior to entering the transitional housing program. An applicant is also eligible after a stay at a hospital or other inpatient setting as long as he or she was homeless according to the above definition immediately prior to the inpatient stay. If the inpatient stay was less than 30 days, the applicant should be counted as coming from their immediate prior place of stay (street or shelter).

I hereby verify that the referred applicant, _____ is currently a guest at: _____
(applicant name)

(Check only one, and complete related information.)

☐ **an emergency shelter**
Name of shelter: _____

☐ **a transitional housing program for less than 2 years and was homeless (in a shelter or on the streets) immediately prior to the transitional housing stay.**

Name of transitional program: _____

Date entered program: _____

Location prior to transitional stay: _____

☐ **an inpatient setting and was living on the streets or in an emergency shelter immediately prior to the inpatient stay.**

Name of inpatient setting: _____

Date entered inpatient setting: _____

Location prior to inpatient stay: _____

☐ **a public/ private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.**

Location of current place: _____

I understand that false statements or information are punishable under Federal Law.

Signature of Authorized Program Staff

Print name and Title

date

This form was copied verbatim from City of Boston's Department of Neighborhood Development, verification of homelessness document

Housing History, Page 1

Note: you can often locate landlord information by using the Tax Assessor's website in each town (or by calling the Tax Assessor's phone number in most towns: To determine if there is an online Tax Assessor page for a town search the web like this: "Tax Assessor, Boston MA" or "Property Assessment, Dallas TX".

CURRENT RESIDENCE

DATES YOU LIVED THERE:

Name on the lease _____ to: _____ or present

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

PRIOR RESIDENCE

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

Housing History, Page 2

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

Housing History, Page 3

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A

RESIDENCE BEFORE THAT

DATES YOU LIVED THERE:

Name on the lease _____ to _____

Address you lived at: _____
Street and Apt# City State Zip

Landlord's Name and Address _____

Landlord Tel: _____

Did this landlord bring any court action against the leaseholder or you? ☐ Yes ☐ No

Did this landlord return your security deposit? (check one) ☐ Yes ☐ No ☐ N/A