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
○	

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.

Complete	*Forthcoming*	
○	○	1. UNIVERSAL PRELIMINARY APPLICATION – 4 pages.
○	○	2. FIVE YEAR HOUSING HISTORY form
○	○	3. MEDICAL CERTIFICATION form
○	○	4. CERTIFICATE OF HOMELESSNESS (if required)

Presumptive Eligibility Information (For Housing Providers use Only)

Date on which
found eligible: M_____D_____Y_____

Date removed
From waitlist: M_____D_____Y_____

Reason/s off list: ☐

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

Additional comments:

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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:

1st 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: ☐ ☐ ☐ ☐ ☐ ☐

Other_____

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

Name/Agency:_____ Phone: _____

Name/Agency:_____ Phone: _____

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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)*

Names of individuals who will live with the applicant	*Relationship to applicant*	*Age*	*Source(S) of income * (Wages, SSI, AFDC, etc.)*	*Monthly Income**	*Annual*
Applicant	self				
			Total Household Income:	$0	$0

** 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.

	Living in a shelter.
	Living on the street (having no fixed, regular, nighttime residence).
	Living in Department of Transitional Assistance Program.
	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.
	Living in and receiving care from an institution not designed for long term residence (e.g. hospital, rehabilitation facility etc.)

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	Doubled up (living temporarily with friends or relatives)
	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).
	Renting an apartment using a transitional subsidy such as AHVP or DMH. 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.
	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..
	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). Rent burdened - paying 75% or more …
	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

H. ADDITIONAL ELIGIBILITY:

Some HIV housing programs require, in addition HIV verification, that applicants belong to other specific population groups. A signature below indicates that the applicant belongs to the target population, in every respect, for this housing resource.

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.

*Applicant Signature:*_____ *Date:*_____

I. AUTHORIZATION OF REPRESENTATION/RELEASE OF INFORMATION:

The applicant authorizes that _____ (Name of Housing Advocate or other representative) is permitted to represent the applicant in the process of applying to this HIV housing opportunity and has permission to release information and receive information related to all matters concerning the applicant in this process. This release may be revoked at any time verbally or in writing.

*Applicant Signature:*_____ *Date:*_____

J. ADDITIONAL COMMENTS: Special Needs

Use this space to briefly note other pertinent information:_____

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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

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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)

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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 that 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 stetting 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