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

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

ADDICTION STABILIZATION OPPORTUNITIES FOR PERSONS LIVING WITH HIV

Overview of Program:
The Living and Recovery Community (LARC) is a 30-90 day intensive residential program which offers comprehensive substance abuse stabilization and case management/housing search services. Such services are provided within a treatment-planning model that is individualized to meet the unique needs of each client. In this way, LARC offers a safe and structured space in which program participants can focus on establishing or re-establishing rituals of recovery and wellness that enhance quality of life.

Populations Served:
LARC serves men and women living with HIV/AIDS and alcoholism and/or drug addiction whose histories of addiction relapse have jeopardized their ability to access and/or maintain stable residency in either treatment or housing programs. LARC fully integrates persons involved in methadone treatment into the stabilization program.

Stabilization Services:
- Pre-Admission Case Management Services
- Individual Addiction/Relapse Prevention Counseling
- Group Counseling (over 30 groups weekly)
- Comprehensive Case Management
- Housing Search Counseling and Advocacy
- Acupuncture Therapies
- Stress Reduction Trainings
- Life Skills Building (including Medication Management)

Program Eligibility Criteria:
- 18 years of age or older
- History of alcoholism and/or drug addiction
- HIV infection
- Medical clearance for inpatient substance abuse treatment (detoxification from all illegal and/or unprescribed substances)
- Recent instability in addiction recovery (relapse)
- Medical condition stability
- Non-infectious tuberculosis status
- Psychiatric and neurological competency to engage in program

Location:
LARC is located on the 11th floor (north) of the Lemuel Shattuck Hospital in Jamaica Plain. The hospital building itself is situated on the edge of Franklin Park within walking distance of the Forest Hills Orange Line T Station.

Facilities:
The LARC program has 15 comfortable single client rooms, 4 spacious bathrooms, an ample kitchen and dining area, a large solarium/group room, an acupuncture treatment room, and several staff office spaces. In addition, LARC has laundry facilities which include clothes washers and dryers. The LARC program is handicapped accessible.

FOR MORE INFORMATION, PLEASE CALL THE LARC PROGRAM
617-522-293

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

Thank you for your interest in the Victory Programs Living and Recovering Community.
The following information is provided to assist you during the admission process.
Please contact Victory Programs Living and Recovering Community with further questions or to make a referral.

ADMISSION DOCUMENTATION

To be eligible for admission, an applicant must provide documentation of the following:

1. A history of alcoholism and/or drug addiction.
2. HIV infection.
3. Medical clearance for inpatient treatment (detoxed from all illegal and unprescribed substances).
4. Recent instability in her/his addiction recovery (relapse or risk of relapse).
5. Non-infectious tuberculosis status
6. Verification of Financial Resources and Expenses

In addition, applicants must be medically stable and psychiatrically and neurologically competent to participate in the program. All applicants must sign consent forms allowing the clinical staff of Victory Programs Living and Recovering Community (LARC) to communicate with their primary care physician, mental health provider(s), methadone provider, and any other relevant care providers.

ADMISSION PROCESS

1. Initial Intake
   The applicant or referring provider contacts LARC and participates in an Initial Intake to verify the applicant's basic program eligibility.

2. Fax Transmittal of Required Documents
   The identified provider coordinates the completion and return of required forms and the submission of appropriate documentation, including:
   - Program Application Form.
   - Physician's Referral Form.
   - Applicant's Consent to the Release of Information Form(s)
   - Financial Resources and Expenses Verification Documentation
   - Methadone Provider's Referral Form (if applicable)

3. Interview
   The applicant comes to LARC for an interview with program staff. This interview includes:
   - an initial needs assessment.
   - negotiation of the treatment fee and verification of insurance (if applicable).
   - clarification of the program requirement that, when admitted, the client is to bring a minimum of two weeks supply of all needed medications.
   - discussion of Pre-Admission Clinical Services.
   - signing of the Client Agreement to Program Participation and the Client Agreement to Rights and Responsibilities.

4. Program Acceptance
   Once the applicant has been accepted for admission to LARC, s/he will be notified by phone.

5. Pre-Admission Clinical Services
   Between program acceptance and admission, the applicant participates in:
   - weekly one-hour counseling sessions with a HART counselor, and
   - weekly 90-minute Orientation Group.

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130
Phone: (617) 522-2936
Fax: (617) 522-1345

REFERRING PROVIDER'S FORM

GENERAL INFORMATION

Applicant's name: _____

Current address: _____

Telephone #: _____

Age: _____ Date of birth: _____ Gender: _____ Pregnant (Y/N) _____

SS#: _____ Language(s) spoken: _____

Has the applicant participated in the LARC program before? _____ When? _____

REFERRING PROVIDER INFORMATION

Name of referring provider: _____

Relationship to applicant: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____

Provider's signature and date: _____

Reasons for LARC Referral:

_____

_____

_____

ADDICTION AND RECOVERY STATUS

Description of applicant's most recent addiction relapse: _____

_____

Description of applicant's current recovery status: _____

_____

Description of current alcohol/ drug usage (if applicable): _____

_____

Description of applicant's detoxification needs: _____

Is the applicant involved in methadone treatment? Yes___ No: ___ Dosage: _____

Methadone provider agency name and #: _____

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MEDICAL INFORMATION AND STATUS

Name of primary care physician: _____

Physician's phone number: _____

Other involved health care agencies (CMA, VNA,…)?: _____

Date of HIV diagnosis: _____

Opportunistic infections and dates: _____

_____

Does the applicant have any neurological involvement related to HIV, and if so, please describe?

_____

_____

Current medications: _____

_____

_____

_____

Current medical status: _____

_____

HOUSING INFORMATION AND STATUS

What is the applicant current housing situation? _____

_____

Is applicant's current housing situation safe? _____

_____

What are the applicant's housing needs? _____

_____

Amount of monthly rental payment (if applicable): _____

MENTAL HEALTH INFORMATION AND STATUS

Is applicant currently seeing mental health care provider? Yes____ No____

How frequently? _____ Date of last visit: _____

Mental health care provider's name: _____

Mental health provider's phone #: _____

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
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Jamaica Plain, MA 02130
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Fax: (617) 522-1345

Psychiatric history (include diagnosis and type of treatment): _____

_____

_____

CASE MANAGEMENT INFORMATION

What are the applicant's immediate case management needs? _____

_____

_____

What workers/ agencies are providing case management support to the applicant at present?

_____

_____

LEGAL ISSUES

Does the applicant have legal cases pending, and if so, what is the current status of these legal issues?

_____

_____

_____

FINANCIAL INFORMATION

Applicant's total current monthly household income: _____

Current sources of income (include employment, benefits, food stamps, other sources):

_____

_____

Medicade number and type: _____

Recipient identification number (if applicable): _____

Other Insurance (CMA, NHP, HCHP)? _____

Support Status

Married: ____ Unmarried: _____ Divorced: _____ Widowed: _____ Couple: _____

Name of significant other (if applicable): _____

Does applicant have children, and if so, how many? _____

Describe applicant's "family" and/or system of support: _____

_____

Describe presence of addiction in applicant's family? _____

_____

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

CLIENT'S CONSENT TO THE RELEASE OF INFORMATION

I, _____, authorize the staff of the referring program _____, and the staff of The Living And Recovering Community (LARC) to exchange any information regarding my addiction, health care, and case management needs and resources that may be useful in facilitating my application and possible admission to the LARC program. I understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in the event this consent expires one year from its execution or upon the withdrawal of my application or my discharge from the LARC program.

_____ _____

Signature of Client Signature of Witness

Dated: _____

-

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

Request for Physician's Certification

_____ _____
Name of Client Client's Date of Birth

_____ _____
Name of Primary Care Physician Physician's Phone Number

Authorization for Release of Information

I, _____,
authorize my physician, _____,
to disclose to LARC the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires one year from its executions or upon the withdrawal of my application or my discharge from the LARC program.

_____ _____
Signature Client Signature of Witness

Physician's Certification

I, _____(please print name),

of_____(clinical/hospital affiliation)_____ (phone),

provide primary medical care for _____,
whom I understand, is applying to the Living and Recovering Community Program. I here by certify that he/she:

_____ has a diagnosis of AIDS
_____ is disabled due to HIV
_____ is HIV symptomatic
_____ is HIV asymptomatic
_____ is neither disabled due to HIV nor has a diagnosis of AIDS

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Medical Provider Signature Date

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

PHYSICIAN'S TB CERTIFICATION

I, _____(please print name)

of_____(hospital/clinic affiliation)

provide primary medical care for_____,

I hereby certify that he/she:

____ does have active/contagious TB disease.

____ does not have active/contagious TB disease.

Date of last TB test: _____ Results_____

Date of last chest x-ray: _____ Results_____

Additional Information:

Has this person ever tested positively for antibodies to TB? **Yes ___ No___**

Date of positive test result: _____

Has this person ever had active TB disease in the past? **Yes ___ No___**

Date of tx of active TB disease:_____

Has this person completed a successful course of treatment? **Yes___ No___**

Please indicate related TB medications and dates of use:_____

_____

_____ _____

Medical Provider Signature Date

Methadone Aftercare Agreement
The Living and Recovering Community

Phone: (617) 522-2936
Fax: (617) 522-1345

Client Name: _____ Date of Birth: _____

Home Methadone Clinic: _____

Home Methadone Clinic Fax Number: _____

Home Methadone Contact Person: _____

Home Clinic Phone Number: _____

This is an agreement between the Living and Recovering Community (LARC) of Victory Programs, the client listed above, and his or her home methadone clinic listed above. While at LARC, the client is courtesy dosed at the Methadone Assessment and Treatment (MAT) of Roxbury Comprehensive Community Health Center, located at the Lemuel Shattuck Hospital in Jamaica Plain, the same building in which LARC is located. Upon discharge from LARC the MAT Program ceases courtesy dosing for the LARC client, and the client must return to his or her home clinic for continued dosing.

This is an agreement that, _____
(client name)

will resume services at his or her home clinic, _____,
(home clinic name)

after discharge from the LARC Program. The home clinic will be notified when the client is discharged from LARC by staff of the LARC program and/or the MAT Program. Further arrangements to coordinate care can be made by contacting LARC.

Client Signature: _____ Date: _____

Home Clinic Staff Signature: _____ Date: _____

LARC Staff Signature: _____ Date: _____

Living and Recovering Community (LARC)
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, MA 02130

METHADONE PROVIDER'S REFERRAL FORM

Name of Client	Client's Date of Birth
Methadone Provider Agency	Staff Contact
Mailing Address	City, State and Zip Code
Telephone	Date of Client's Entry into Methadone Program

CLIENT'S CONSENT TO THE RELEASE OF INFORMATION

I, _____,

authorize the above agency, _____,
to disclose to LARC the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFD Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires one year from its execution or upon the withdrawal of my application or my discharge from the LARC program.

Signature of Client	Signature of Witness

METHADONE PROVIDER'S INFORMATION

Briefly describe the client's dosage history: _____
_____
_____
_____

Briefly describe the client's methadone treatment goal (i.e., detox or maintenance):
_____
_____
_____
_____

Documentation of most recent six urine toxicology screens:

Date	Results
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Methadone Provider Staff Signature_____

FINANCIAL RESOURCES AND EXPENSES VERIFICATION GUIDELINES
LIVING AND RECOVERING COMMUNITY OF VICTORY PROGRAMS

170 MORTON STREET, 11 NORTH
JAMAICA PLAIN, MA 02130
PHONE: (617) 522-2936 FAX: (617) 522-1345

In order to facilitate the housing search process and/or determine an appropriate LARC program fee, documentation of financial resources is required. Therefore,

If this is the Applicant's Situation:	Please Submit the Following:
▪ Applicant receives General Relied, Social Security, SSI, Aid to the Blind, Veterans' Benefits, Etc.	▪ A copy of applicant's most recent award letter, or a letter to applicant from the agency making the payment that clearly states the amount of the monthly payment.
▪ Applicant is self-employed	▪ A certified copy of applicant's most recent Federal 1040 Form.
▪ Applicant receives special payment that replaces earnings such as Unemployment Compensation or Disability payments.	▪ An award letter to applicant from the institution making the payment clearly stating the amount and frequency of the payment.
▪ If applicant receives income from a pension or annuity.	▪ A letter to applicant from the institution making the payment that clearly states the amount and frequency of the payment.
▪ A member of applicant's household is employed.	▪ Four recent pay stubs or a letter from the employer stating gross income for each employed family member.
▪ Applicant receives interest, dividends, or earnings from an investment.	▪ The latest monthly, quarterly, or annual statement from the bank or other institution clearly stating the amount and frequency of payments. ▪ A written notarized statement, signed by the person making the payments, stating the amount and frequency of whatever payments applicant receives.
▪ Applicant receives regular contributions from another person such as alimony, support payments, etc.	▪ Copy of applicant's bankbook or most recent bank statements.
▪ Applicant has a bank account.	▪ Canceled checks, receipts, or letters from doctors or pharmacists verifying the amount of expenditure.
▪ Applicant is elderly, handicapped, and/or disabled and has significant medical expenses.	▪ Letter from landlord or property manager stating the address of the identified rental property and the amount and frequency of rental fee obligations.
▪ Applicant is paying rental fees for existing housing.	

Note: Verified non-existence of income in itself will not exclude individuals from participation in LARC

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