SUBMITTING YOUR COMPLETED APPLICATION

For more information or to submit a completed application, please contact one of the following agencies depending on County preference.

ANDROSCOGGIN, FRANKLIN, AND OXFORD COUNTIES

Common Ties

P.O. Box 1319

Lewiston, ME 04243

Tel. 207-795-6710 Fax: 207-795-6714 (Attn: Housing)

YORK, CUMBERLAND, KNOX, LINCOLN, SAGADAHOC, AND WALDO COUNTIES

Shalom House, Inc.

106 Gilman Street

Portland, ME 04102

Tel. 207-874-1080 Fax: 207-874-1077 (Attn: BRAP)

AROOSTOOK, HANCOCK, PENOBSCOT, PISCATAQUIS, AND WASHINGTON COUNTIES

Community Health & Counseling Services

P.O. Box 425

Bangor, ME 04402-0425

(42 Cedar Street, Bangor, ME 04401)

Tel. 207-947-0366

KENNEBEC AND SOMERSET COUNTIES

Kennebec Behavioral Health

67 Eustis Parkway

Waterville, ME 04901

Tel. 207-873-2136 Fax: 207-660-4532

BRIDGING RENTAL ASSISTANCE PROGRAM (BRAP)
APPLICATION

First Name: _____ **Last Name:** _____

Gender: ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Gender Non-Conforming

Social Security Number: _____

DOB:_____

Veteran: YES ☐ **NO** ☐ **Are you Hispanic or Latino?** ☐ Yes ☐ No

Race (check all that apply):

☐ American Indian or Alaskan Native
☐ Black or African-American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

Mailing Address: _____

Telephone Number: _____

Preferred Counties (1st & 2nd choice): _____

1. **Is the applicant an AMHI Consent Decree Class Member?** **YES** ☐ **NO** ☐
   *****(A Consent Decree Class Member is someone who was hospitalized at AMHI/Riverview Psychiatric Center on, or after January 1, 1988.)

2. **Does Applicant meet Eligibility For Care for Community Support Services?**
   *****(As defined in Section 17 of the MaineCare Benefits Manual effective 4/08/2016) **YES** ☐ **NO** ☐
   ****If you answered 'no' to questions #1 and #2 you are not eligible for assistance under BRAP***

3. **Is the applicant currently receiving SSI or SSDI (Attach documentation dated within 120 days of application date)?** **YES** ☐ **NO** ☐

4. **If no, are you in the process of applying for or appealing SSI or SSDI (Attach documentation of application or appeal)?** **YES** ☐ **NO** ☐
   ****If you answered 'no' to questions #3 and #4 you are not eligible for assistance under BRAP***

5. **Is applicant currently on a waitlist for federally subsidized housing?** **YES** ☐ **NO** ☐
   5A. If 'No' why? _____.

*****<u>ATTACH VERIFICATION</u> FROM THE HOUSING AUTHORITY OR MANAGEMENT COMPANY WHERE YOU APPLIED FOR SUBSIDIZED HOUSING AND/OR SECTION 8.***

6. Correspondence: Do you want us to copy all correspondence (i.e., acceptance letter, denial letter, debt information) **to your referral source or other service provider?** If yes, please provide name, address, and phone number for all that apply.

Payee: **YES** ☐ **NO** ☐ _____

Case Manager: **YES** ☐ **NO** ☐ _____

Guardian: **YES** ☐ **NO** ☐ _____

Service Provider: **YES** ☐ **NO** ☐ _____

7. Household Composition: Please list everyone who will be residing in the household.
Please note: Each additional Household Member must complete and attach a Household Member Form

Name:	Relationship to Applicant:	Pregnant:
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

8. Applicant Income & Other Assistance Sources:

Documentation of current monthly income must be attached.

Income Sources		**Other Assistance Sources**
No financial resources	$_____	☐ None
Supplemental Security Income (SSI)	$_____	☐ SNAP / Food Stamps
Social Security Disability Income (SSDI)	$_____	☐ Medicare
Social Security	$_____	☐ Medicaid (MaineCare)
Employment income	$_____	☐ SCHIP
General Public Assistance (GA)	$_____	☐ VA Medical Services
Unemployment benefits	$_____	☐ WIC
Temporary Aid Needy Families (TANF)	$_____	☐ TANF (Child Care / Transp.)
State Supplement	$_____	☐ Indian Health Services
Other (Source): _____	$_____	☐ Employer Provided Insurance
		☐ Other (Source): _____
TOTAL Monthly INCOME:	$_____	

9. Please indicate priority and <u>ATTACH VERIFICATION</u> for <u>all</u> that apply:

Priority 1

Psychiatric Discharge: BRAP Applicants who are being discharged from Riverview Psychiatric Center or Dorothea Dix Psychiatric Center, private psychiatric hospitals, or who have been discharged in the past thirty (30) days and were admitted to a Psychiatric facility for a period greater than seventy-two (72) hours. Also, BRAP Applicants who are moving from Community Residential Treatment Programs, 10-144 C.M.R. Ch. 101 MaineCare Benefits Manual, Ch. II Section 97, Appendix E, to less restrictive accommodations, to allow for appropriate discharges, as determined by the clinical team from the institutions mentioned above. *Intake and/or discharge paperwork from institution or program referenced above with a clear intake and discharge date must be attached.*

☐ Applicant is being discharged from a State Psychiatric Hospital (RPC or DDPC) after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;

☐ Applicant is being discharged from a private psychiatric hospital after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;

☐ Applicant is moving from a Community Residential Treatment Program (Mental Health PNMI), to less restrictive accommodations to allow for appropriate discharges, as determined by the clinical team from the institutions mentioned above;

☐ Applicant has been discharged within the past thirty (30) days from a State Psychiatric Hospital (RPC or DDPC) after a seventy-two (72) hour or greater psychiatric inpatient hospital admission;

☐ Applicant has been discharged within the past thirty (30) days from a private psychiatric hospital after a seventy-two (72) hour or greater psychiatric inpatient hospital admission.

Priority 2

Applicant is being released within the next thirty (30) days from a Correctional Facility and meets Section 17 criteria; or Applicant has been released within the past thirty (30) days from a Correctional Facility and meets Section 17 criteria; or Applicant has been adjudicated through a Mental Health treatment court and meets Section 17 criteria, who have no subsequent residences identified. *Intake and/or release paperwork from Correctional Facility referenced above on agency letterhead stating Correctional Facility, dates of stay, and include the title of the person completing the verification must be attached.*

☐ Is being released within the next thirty (30) days from a Correctional Facility and no subsequent residences have been identified;

☐ Has been released within the past thirty (30) days from a Correctional Facility and no subsequent residences have been identified;

☐ Has been adjudicated through a Mental Health treatment court and documentation is attached.

Priority 3

Applicant is Literally Homeless, as defined by HUD. Applications received are on a ranked basis according to length of homelessness, with those being homeless the longest as the top priority. *Verification of current living situation typed on agency letterhead stating current living situation, length of stay and dates of homelessness; include title of person completing the verification. The last documented incidence must be dated within 14 days of application submission. Please note: Eviction proceedings and living with family and/or friends does not meet the qualification guidelines for literal homelessness.*

☐ *Chronic Homelessness:* Documented Literal Homelessness *(homeless continuously for at least 365 days or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months);or*

☐ *Long Term Stayer:* Documented Literal Homelessness *(180 nights of past 365 days);*

☐ Living in a place not designed for habitation such as cars, parks, sidewalks, and abandoned or condemned buildings. This may include persons who ordinarily sleep in one of the above places but are spending a short time (90 consecutive days or less) in a hospital or other institution;

☐ Living in an Emergency Shelter or hotel/motel with emergency funds;

☐ Living in Transitional Housing for homeless persons (*verification of homelessness prior to program entry must be attached.)*

Applicants are encouraged but not required to engage in services as a condition of acceptance into the Bridging Rental Assistance Program.

10. CERTIFICATIONS:

_____ **Initials** Any previous BRAP/SPC recipient may re-apply for subsidy, as long as he or she is eligible and in good standing with any housing subsidy program administered by DHHS (Bridging Rental Assistance Program &/or Shelter Plus Care). Applicants, who owe any DHHS administered housing subsidy program for back rent, damages, security, etc., may be considered for readmission providing that one of the following minimum criterions have been met:

- 100% of account balance must be paid before move in and/or unit transfer; or
- Establishment of a Representative Payee and a documented payment plan not to exceed 12 months

Failure to meet at least one of the above criterions may result in program in-eligibility.

_____ **Initials** Section 8 compliance: I understand that one of the eligibility criterion for BRAP is that I must maintain an active application for federally assisted housing during my entire tenure with BRAP, with a local Public Housing Authority or Administrator. If a wait list is closed, I understand that I am obligated to get on the list at the earliest opening date. I understand that if I do not comply with this and other requirements detailed in the Tenant Responsibility Agreement, I may be immediately terminated from BRAP.

_____ **Initials** Release of Information: I/We agree to complete the necessary release(s) of information which will allow_____(Name of LAA) to obtain, verify, and document information pertaining to initial and ongoing eligibility for rental assistance provided under this program.

_____ **Initials** Release of information: I/we agree to have any and all correspondence relating to initial and ongoing eligibility for rental assistance copied to my guardian and/or representative payee and/or other designated person as identified in Question 6.

_____ **Initials** Tenant's Certification: I/We certify that the information contained in this application is true and complete to the best of my/our knowledge and belief. Failure to furnish true, accurate, and complete information, now or in the future, will result in one or more of the following: termination from program, eviction, formal investigation, legal action. Intentionally submitting false or incomplete information, including but not limited to submitting false household income and/or composition, is a crime.

_____ **Initials** If you were homeless prior to enrolling in BRAP: The Bridging Rental Assistance Program you are a participant in the statewide Homeless Management Information System (HMIS). Participation in the BRAP program means your information and the information of your household members will be submitted to a secure database so that Maine can generate mandated federal reports about homelessness.

Print Applicant Name	Applicant Signature	Date
Print Name–Other Adult Member	Other Adult Member Signature	Date

ELIGIBILITY VERIFICATION

1. I hereby affirm the above-enclosed information concerning current housing situation, current address, and eligibility criteria are true and accurate for this client as indicated above; and

2. I verify the Applicant meets the Eligibility For Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual or is already enrolled in PNMI services:

   CHECK APPROPRIATE BOX and ATTACH VERIFICATION:

   i. ☐ Applicant is already enrolled in Adult Mental Health Services funded Community Support (Section 17) and/or PNMI services (Section 97)—verification of enrollment with KEPRO HealthCare or DHHS attached; **OR**

   ii. ☐ No KEPRO HealthCare or DHHS Adult Mental Health Enrollment form is currently on file. I have attached a completed BRAP Enrollment Form to provide a mental health diagnosis or have attached such a signed qualifying diagnosis my agency deems appropriate to document eligibility for services under Section 17 as may be approved by KEPRO HealthCare and/or DHHS to the BRAP Enrollment Form.

Referring Agency: _____

_____	_____	_____
Printed Name	Signature	Date

LAA OFFICE USE ONLY

Representative Signature: _____ **Date:** _____

Program: _____ **Slot assigned:** _____/_____/_____ **Slot Size:** _____

Date Housed in program: _____/_____/_____ **Worker Assigned:** _____

Office of Adult Mental Health Services
BRAP ENROLLMENT FORM

To be completed ONLY for persons not already Enrolled in Section 17 Services AFTER April 7, 2016

Client Information:

Name: _____

Date of Birth: _____

Social Security Number: _____

Diagnosis and LOCUS Information:

Primary Diagnosis: _____

Date Given: _____

LOCUS Score:_____ Rater ID:_____

Date Given: _____

Requirements for Eligibility. A person is eligible to receive covered services if he or she meets both general MaineCare eligibility requirements and specific eligibility requirements for Community Support Services under Section 17 of the MaineCare Benefits Manual.

General Requirements. Individuals must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

Risk Factors: Documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis.

Specific Requirements. A member meets the specific eligibility requirements for covered services under this section if:

A. The person is age eighteen (18) or older or is an emancipated minor with:

1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
2. Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:
   a) has a written opinion from a clinician, based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or
   b) has received treatment in a state psychiatric hospital, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   e) has been committed by a civil court for psychiatric treatment as an adult; or
   f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

AND

B. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.

C. Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both.

D. The LOCUS or other approved tools must be administered, at least annually, or more frequently, if DHHS or an Authorized Entity requires it.

History Of (check all which apply):

- ☐ Has received treatment in a state psychiatric hospital, within the past 24 months;
- ☐ Has been discharged from a mental health residential facility, within the past 24 months;
- ☐ Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months;
- ☐ Has been committed by a civil court for psychiatric treatment as an adult;
- ☐ Until the age 21, the recipient was eligible as a child with severe emotional disturbance.*****

***** If selecting this qualifier, please indicate a written opinion stating that the recipient, in the last 12 months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

Based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of (check all which apply):**

- ☐ Homelessness;
- ☐ MH Residential treatment;
- ☐ MH inpatient greater than 72 hours;
- ☐ Criminal Justice involvement.

****** Reported history may include oral or written history from the client, a provider, or a caregiver

Signatures and Certifications:

I, _____, certify and attest that the diagnostic
Clinician Signature
information listed on the previous page (7) are in accordance with the Specific Requirements section of this form (Part A, paragraph 2, sub-paragraph a) and is true and complete to the best of my knowledge and belief.

_____

Print Name and Credentials ***(must be MD, LCSW, LCPC, PhD, APRN, NPC, PA or DO)***

Date:_____

Maine's HMIS Authorization to Disclose Information

Agency:_____

For:_____ _____
Print First, Middle, and Last Name (Complete one form for each adult) Date of Birth

Children/Incapacitated Persons:_____ _____
Date of Birth

_____ _____
Date of Birth

_____ _____
Date of Birth

Your personal information is confidential. We and anyone with access to the information we collect from you must keep your information confidential and protect the information under strict safeguards. Your personal information and that of the above listed persons for whom you have authorization to sign will be collected by the above Agency and entered into Maine's Homeless Management Information System (HMIS). With your consent, your personal information, including historical information in HMIS, will be made available to other agencies providing services to you through HMIS.

A list of agencies participating in HMIS that may have access to your information if you sign this authorization is at www.mainehmis.org and available from Agency.

Why disclose your information to other agencies?

- Sharing reduces the amount of time you have to spend answering basic questions about your situation.
- Sharing allows agencies to focus on meeting your unique needs quickly.
- Sharing makes it easier for multiple agencies to coordinate housing and services for you and your family.

What information might be disclosed to other agencies?

- Family/Household Information
- Name, birthdate, Social Security Number
- Gender, race, ethnicity
- Reasons for seeking services
- Living situation and housing history
- Services you receive
- If you are homeless or not
- Your income and income sources
- Disabling condition(s)
- Public benefits you receive
- History of domestic violence
- Educational background
- Employment information
- Military history
- Health information, including physical health, HIV, behavioral health (mental health and substance use disorder information)

Please check (✓) a box:

☐ **DISCLOSE (Share):** I consent to have the information collected by Agency about me and historical information about me already in HMIS disclosed through Maine's HMIS to other partner agencies in order to improve services to me and the services offered to others. I intend that this authorization permit Agency to disclose through the HMIS system any HIV, mental health and substance abuse or substance use disorder information Agency may collect about me. Maine law requires us to tell you that releasing HIV information may have implications. Release of HIV information may help us better serve you. However, misuse of the information could result in discrimination.

This consent does not apply to any information collected by Milestone Recovery, Shaw House, New Beginnings (not including 169 Holland Street), Preble Street (only Joe Kreisler Teen Shelter or youth related project), any Runaway and Homeless youth program or any victim service provider.

☐ **DO NOT DISCLOSE (Do Not Share):** I do **not** want **any** of the information collected by Agency about me disclosed (shared) to any other agencies through Maine's HMIS. I understand that not disclosing my information to other agencies may affect the ability to quickly and appropriately identify services for me.

Maine's HMIS Authorization to Disclose Information

When you sign this form, it shows that you understand the following:

- You have the right to refuse to sign this authorization.
- **Agency** will **not** deny you help if you do not want us to disclose your personal information to other agencies. At the same time, disclosing your information does not guarantee that you will receive assistance from the recipient agency.
- If you permit us to disclose your information to other agencies:
  - This consent is valid for one (1) year.
  - You have the right to review any mental health information that may be disclosed under this authorization, upon request prior to signing this authorization.
  - You may change your mind and cancel this authorization at any time. If Agency is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, see Agency's HIPAA Notice of Privacy Practices on how to revoke this authorization. If you cancel this authorization, your information will no longer be disclosed from that date forward, except to the extent that your authorization has already been relied upon by Agency or others.
- Subsequent disclosures may be made under this same authorization.
- Your information may be disclosed by someone who receives the information and no longer protected.
- You have the right to receive a copy of this authorization.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF AGENCY WITNESS	DATE
_____	_____	_____	_____

☐ **Verbal Authorization obtained by phone (Agency Staff Signature):_____ Date:_____**

<u>If client chooses not to disclose their information, ask that they put a check mark next to the "Do Not Disclose" box and sign the document. Fax to: HMIS Team 207-624-5768. Visibility from this point forward will be removed.</u>

Maine's HMIS Authorization to Disclose Information

Maine's HMIS Notice of Privacy Practices

This Agency (Name: _____) and other service providers, homeless agencies and social service agencies, including street outreach, shelters and housing programs, collect personal information about the people we serve in a computer system called Maine's Homeless Management Information System (HMIS). *If Agency is a HIPAA covered entity, this HMIS Notice of Privacy Practices is a supplement to Agency's HIPAA Notice of Privacy Practices, and you should also review Agency's HIPAA Notice for additional information about how Agency protects the privacy and security of your protected health information.* This HMIS Notice of Privacy Practices may be amended at any time and an amendment may affect information given to the Agency prior to the amendment.

Why do we collect this information?

- So we know how many people we serve and the types of people we serve at our Agency and in the state.
- So we all understand what people need and can plan services to meet those needs.
- To satisfy U.S. Department of Housing and Urban Development requirements.

Who can see information that is in Maine's HMIS?

- People who work for this Agency will use it to help provide services to you or your family.
- Other agencies like this Agency that provide services and have received permission from you to see your information. The agencies that participate in Maine's HMIS may change from time to time. A copy of the current list of participating agencies is available upon request or on our website: www.mainehmis.org.
- Auditors or funders who have legal rights to review the work of this Agency, such as the U.S. Department of Housing and Urban Development and other state or local government entities.
- Organizations that run, administer, and work, on the HMIS system. When these organizations work on the system, they may see information about you. They are required to protect your confidential information.
- The law says we have to report physical or sexual abuse of children and vulnerable adults. If we have cause to suspect that there is abuse or neglect in your household, we must report it to Child or Adult Protection.
- We may disclose your information to protect the health or safety of you or others as required by law.
- Others as required by law, including officials with a valid subpoena, warrant, or court order.
- We may disclose your information to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public

We will not disclose your information for any other use unless you permit us in writing.

How is your privacy protected?

- All users of HMIS data must sign an agreement to protect your privacy and comply with state and federal laws and policies before seeing any information.
- The HMIS computer program used for this purpose has industry standard security safeguards and protocols and is updated regularly to meet these security requirements.

What are your rights?

- **If you do not want your name, social security number, or date of birth entered in HMIS, tell the intake worker.** This Agency will **not** refuse to help you if you refuse to authorize Agency to share your information with other providers/ agencies through HMIS. However, federal and state regulations may require limited data collection for funding purposes.
- You have the right to request a copy of Maine's HMIS information about you.
- You have the right to correct mistakes in HMIS information about you.
- If you think this Agency or Maine's HMIS violated your privacy rights, you have the right to complain or appeal. Ask a staff person for a complaint and appeal form. *If Agency is a HIPAA covered entity, see Agency's HIPAA Notice of Privacy Practices for information about how to file a HIPAA privacy complaint.*

DHHS SUBSIDY PROGRAMS
BRAP / SPC Household Member Form

Instructions: Please complete a Household Member form for each additional household member who will be residing in the unit.

**If form is not completely filled out, the LAA reserves the right to return the application.*

1. Household Member Name: _____

2. Program: ☐ BRAP ☐ Shelter Plus Care

3. Relationship to HOH: _____

4. Gender: ☐ M ☐ F ☐ Transgender M to F ☐ Transgender F to M ☐ Gender Non-Conforming

5. Date of Birth: _____ **6. Social Security Number:** _____

7. Are you a Veteran? ☐ Yes ☐ No

8. Are you Hispanic or Latino? ☐ Yes ☐ No

9. Race (check all that apply):

☐ American Indian or Alaskan Native
☐ Black or African-American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

10. Do you have a Disabling Condition? ☐ Yes ☐ No

If yes:

☐ Severe Mental Illness
☐ Alcohol Abuse
☐ Chronic Health Condition
☐ HIV/AIDS
☐ Drug Abuse
☐ Physical Disability
☐ Developmental Disability

11. Income and Other Assistance Sources: *Documentation of current monthly income must be attached.*

Income Sources:	*Monthly Amount:*	*Other Assistance Sources:*
☐ No Financial Resources	$_____	☐ None
☐ Supplemental Security Income (SSI)	$_____	☐ SNAP/Food Stamps
☐ Social Security Disability Income (SSDI)	$_____	☐ Children's State Health Program (SCHIP)
☐ Social Security Retirement	$_____	☐ Medicare
☐ Employment income	$_____	☐ MaineCare
☐ General Public Assistance (GA)	$_____	☐ Veterans Health Care
☐ Unemployment Benefits	$_____	☐ Employer-Provided Health Insurance
☐ Temporary Aid Needy Families (TANF)	$_____	☐ Indian Health Services
☐ State Supplement	$_____	☐ WIC Insurance
☐ Other (Source): _____	$_____	☐ Other (Source): _____

TOTAL MONTHLY INCOME: $_____

12. Where are you currently residing?

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, tent, camping site, or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Foster care home or foster care group home
- ☐ Hospital (non-psychiatric)
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-Term Care Facility or Nursing Home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with other (non-VASH) ongoing housing subsidy
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional housing for homeless persons (including homeless youth)

Length of Stay: _____ | Zip Code: _____

13. If coming from a Homeless Situation:

How many separate times have you been on the streets or in a shelter in the past 3 years? _____

Approximate Date Homelessness Started: _____/_____/_____

14. Are you a victim or survivor of domestic violence? ☐ Yes ☐ No

14a. If yes, when:

- ☐ Within the past three months ago
- ☐ Three to six months ago
- ☐ From six to twelve months ago
- ☐ More than a year ago
- ☐ Don't Know
- ☐ Refused to Answer

14b. If yes, are you currently fleeing? ☐ Yes ☐ No ☐ Refused

Tenant's Certification: By signing below, I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

APPLICANT or HOUSEHOLD MEMBER (18+) or GUARDIAN SIGNATURE **DATE**